Magellan Behavioral Health
Provider Manual
&
Web Site User Guide

5/19/2010

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Magellan Behavioral Health
Provider Handbook
Division of Behavioral Health Services

Introduction and Overview

Magellan Behavioral Health (Magellan) is contracted with the Nebraska Department of Health and Human Services (DHHS) Division of Behavioral Health Services as an Administrative Service Organization (ASO). The Division of Behavioral Health (DBH) contracts with Magellan for the following:

1. Registration and authorization of mental health, substance abuse, and gambling assistance program services for individuals meeting financial and clinical eligibility criteria;
2. Utilization management of mental health, substance abuse, and gambling assistance program services;
3. Data management and reporting for mental health and substance abuse services;
4. Training, consultation and public education.

This handbook is designed to give providers contracted with the Division of Behavioral Health Services specific information on the administrative services provided by Magellan. Compliance with the procedures outlined in this provider handbook, and the Nebraska Health and Human Service System Behavioral Health and Medicaid Adult Service Definitions (aka "Yellowbook") is required for services that are reimbursed through the Division of Behavioral Health Services.

Service Philosophy

Magellan is committed to endorsing and supporting in practice the overall philosophy of the DHHS for the provision of treatment and rehabilitative services. Specifically the principles of family/consumer centered practice and community based, recovery oriented, developmentally and culturally appropriate services as well as trauma informed care. Additionally, Magellan is committed to the provision of treatment at the most appropriate, least restrictive level of care necessary to provide safe and effective treatment to meet the individual's clinical needs. We view the continuum of care as a fluid treatment pathway, where individuals may enter treatment at any level and be moved to more or less intensive settings or levels of care as their changing clinical needs dictate. Magellan believes in providing the right treatment, in the right amount, at the right location, for the right length of time.

The Magellan Nebraska CMC is also committed to offering frequent training to providers across the State covering a variety of mental health and substance abuse related topics. Magellan has partnered with national experts in behavioral health recovery and resiliency to offer online recovery and resiliency trainings for consumers, family members, providers, and stakeholders. Available in English and Spanish, these trainings are free of charge and available to Nebraska consumers and providers through Magellan's web site www.magellanhealth.com/training.

Regional Behavioral Health Network

Nebraska has six Behavioral Health regions which comprise the Behavioral Health Services system. Magellan Behavioral Health manages the mental health and substance abuse services for each of the six regions. In order for providers to obtain authorizations/registrations from Magellan for these services, they must first be contracted with one or more of the six regions who perform provider approval for their respective provider networks. Magellan does not credential or contract providers for the Behavioral Health Services network; however Magellan does maintain a provider database in order to administer the authorization/registration process. When a new provider is contracted with a Region, provider identifying information is provided to Magellan by DHHS and the website login and password are created and communicated to the provider via e-mail.

The regions pay claims for contracted mental health and substance abuse services when the client meets clinical and financial eligibility for the service. Nebraska Medicaid pays claims for eligible consumers receiving Medicaid Rehabilitation Option (MRO) and Adult Substance Abuse (ASA) services through providers contracted with the Regions (see Magellan Behavioral Health, Provider Handbook Supplement For the Nebraska Medicaid Managed Care Program & Nebraska Medical Assistance Program for details. This information can be located at www.magellanprovider.com.

The map below illustrates the six Behavioral Health regional areas within the Behavioral Health Services system.

Consumer Eligibility

Consumer eligibility to receive services through the Behavioral Health System is based upon two specific sets of criteria, clinical and financial. Each network program is required to have a sliding fee schedule for self pay clients. It is the network's responsibility to assess self- pay clients for financial eligibility. Magellan's utilization management process is used to determine clinical eligibility.

Service Descriptions

The Behavioral Health Service Definitions and Clinical Guidelines, located on the web at http://www.hhs.state.ne.us/beh/bhsvcdef.htm includes service descriptions for each Nebraska Behavioral Health adult authorized service. Service descriptions are intended to describe what is being purchased as well as ensuring a quality standard. Providers must also follow other state and/or federal standards and regulations that may apply to the service they provide. The Behavioral Health/Magellan approved Clinical Guidelines for each service are used by Magellan's clinicians to determine the clinical necessity of treatment for DSM-IV disorders.

Each set of Clinical Guidelines is characterized by admission, continued stay, and discharge criteria. The continued stay of a patient at a particular level of care requires the continued stay criteria to be met. Magellan expects that active discharge planning begins at the point of admission and continues throughout the treatment course. The discharge guidelines reflect the circumstances under which an individual is able to transition to a less intensive level of care. The Clinical Guidelines were developed by Magellan medical and clinical staff, Nebraska DHHS medical and clinical staff, and clinical/medical consultants, national experts, internal experts in a particular subject area, standard clinical references, and guidelines from professional organizations. The Guidelines will used to determine the safest, most effective and least restrictive level of care.

Service Registration and Authorization Process

All Behavioral Health services must be either registered or authorized. In both cases the process begins with the provider accessing Magellan's website at www.magellanprovider.com using their assigned a website login and password. It is the provider specific login that establishes the relationship between the provider, the consumer and the registration or authorization in the Magellan data system.

Registered Services

Registered services are transacted entirely on the Magellan provider website at www.magellanprovider.com. Providers logon to the website, select “New Registration” and complete the four screens that follow. The last screen presents service type choices (see list below) so the provider can select the service type to be registered.

Assess/Eval Only – MH	Crisis I/P – Youth
Assess/Eval Only – SA	Day Support
Assess/Eval Only – Justice	Detox
CPC	EPC
Ch Day Treatment	Emer Psych Obs 23:59
Ch Halfway House	Emergency Comm Supp
Ch Home Based MST	Family Navigator
Ch IOP –SA	Int Case Mngt – MH
Ch Med Management	Int Case Mgnt – SA
Ch O/P – MH	Medication Management
Ch O/P - SA	OpiodRplace - MethBup
Ch Ther Community	O/P Dual Dx
Ch Partial	O/P – MH
Ch Prof Part School	O/P – SA
Ch Prof Partners	Pre-Auth (See note below)
Ch Yth Assess Only – MH	Psych Respite
Ch Yth Assess Only – SA	Psychological Testing
Ch Respite	Recovery Support
Crisis Assess/Eval – MH	Supported Employment
Crisis Stabilz/Tx	Supported Living
Crisis Assess LDAC – SA	

Authorized Services

For authorized services (see list that follows) there is a two step process where the provider completes a "pre-authorization" at www.magellanprovider.com in the same manner as they would a registration. **Note:** The pre-authorization is an abbreviated form of the registration without the clinical component. On the last screen where the service type choices appear the provider must select "Pre-Auth". The provider must then call Magellan and speak with a Care Manager who will review the applicable clinical information, determine if clinical criteria are met, and complete the service authorization.

Acute Inpatient	Community Support - SA	Halfway House – SA
Sub-Acute Inpatient	Day Rehabilitation	Dual Disorder Residential Tx
Psych Residential Rehab	Intensive Outpatient – MH	Day Treatment – MH
Assertive Community Tx	Intensive Outpatient – SA	Secure Residential
Assertive Comm Tx (Alt)	Short-term Res Tx – SA	Outpatient – (**Medicaid ASA Only**)
Community Support - MH	Therapeutic Comm - SA	Intermediate Residential - SA

More detailed information regarding the registration and authorization process is contained in the Magellan "Logon and Web Site Training Manual" available to providers at www.magellanprovider.com or by contacting the Magellan's Nebraska Care Management Center.

Utilization Review for Authorized Services

After the provider has completed the pre-authorization process on-line, the Magellan care manager reviews the case with the provider to establish whether or not the consumer meets the Medical necessity criteria for the service requested. The care manager will request the following standard clinical information during the verbal utilization review with the provider.

Admission Reviews:

1. Presenting Problem Information: How does the individual or family members describe current issues resulting in need for services? What is provider/facility's understanding of the individual's current problem? Are the individual's and provider's views consistent? If not, how will this impact treatment planning?

2. Precipitating/Proximal Events/Why Now?: Specific reason, why the individual presents for treatment now versus last month?

3. Current Symptoms: Clinical picture and symptoms

4. Mental Status (MSE): Results of Mental Status Exam

5. Risk Assessment: Danger to self/others, plan, history of attempts, psychosis, means, pregnant, substance abuse.

6. Personal Strengths: Insight, coping skills, motivation, perseverance, treatment compliance, periods of stabilization, interests, empathy, etc.

7. Functional Impairments: Activities of Daily Living (ADLs), education, vocations, social, recreational specifics, special needs. Are the impairments related to an Axis I diagnosis?

8. Substance Abuse: List substances used, route, dose, frequency and last use. Document actual substance use. Is the consumer self-medicating? If the request is for a substance abuse treatment, we ask for information on the six dimensions; see "Behavioral Health and Managed Medicaid Managed Care, Mental Health Service Definitions and Utilization Guidelines"

9. Medical Concerns: Vitals, withdrawal symptoms, pregnant, meds, neurological, medical issues—confirm client is medically clear.

10. Primary Care Physician (PCP): Level of involvement, notification requested

11. Current Medications: List all meds (psychotropic/other medical), compliance-other relevant issues with meds.

12. Family and Community Supports: Family, peers, friends, church

13. Legal Status/History: Mental Health Board, legal involvement, pending charges.

14. Treatment History and Previous Solutions: Successes, service combinations, medications.

15. Current Provider: Case worker, Outpatient Therapist, Psychiatrist, other—involvement, notification or referral updates.

16. Last Hospitalization: If applicable

17. Diagnosis: DSM-IV diagnosis (at minimum, Axes I, II and III), Severe, Profound Mental Illness (SPMI)

18. Initial Treatment Plan: How are current "why now" issues being addressed?

19. Discharge Plan: Outpatient provider(s) include "why now" information.

20. Transfer: If request is for inpatient care, medical clearance for hospital transfer if necessary.

Concurrent Review for Authorized Services:

The care manager will require additional information at established intervals in order to consider a continuation of treatment. The care manager may ask for the following information verbally or in writing.

1. Additions to admission information: Newly discovered/assessed information

2. Risk Assessment: Danger to self/others

3. Diagnosis: DSM-IV diagnosis (five Axes)

4. Medication: Medication changes

5. Medical Status: Changes in medical status

6. Treatment Status: Identified progress/barriers, changes to treatment plan

7. Supports: Family/support system involvement

8. PCP: Coordination with primary care physician and other providers

9. Discharge Plan: Including aftercare provider, appointment date/time.

Many continuing stay requests for services are completed via simple one page request forms. They must be faxed or mailed to Magellan prior to the existing authorization end date. These forms are available on line in Appendix C of the Magellan Behavioral Health Provider Handbook Supplement for the Nebraska Medicaid Managed Care Program & Nebraska Medical Assistance Program as "Medicaid Rehabilitation Option Services" and "Substance Abuse Treatment – Continued Service Request". Failure to send the appropriate request for continued service form to Magellan by the authorization end date may result in a break in the service authorization. Please fill in the re-authorization request form completely to avoid delays in the review being completed. Be sure to enter specific rehabilitation plan goals and progress on each, as well as the current discharge plan. These goals and progress must relate the clinical reason for admission to the service. Once treatment/rehabilitation goals are met, it is expected clients will be discharged to appropriate services and supports. Discharge planning is an integral part of the overall treatment plan and must include information regarding your relapse/crisis plan.

Once all the clinical and demographic information is collected the Magellan care manager, working collaboratively with the provider, may make a decision to authorize the service for a specified period of time. If the care manager has questions regarding the clinical necessity for the requested level of care, Magellan's Medical Director (psychiatrist) will be consulted to review the request. The Medical Director may authorized the requested service or non-authorize the requested service and offer an alternative level of care.

Appeal Process

Peer Review

When the Care Manager cannot determine that the clinical guidelines are met, or there is a question regarding the level or quality of care, the case will be referred for Peer Review. Peer review will be conducted for cases where a clinical determination to authorize cannot be made by the Care Manager, and the provider requests the Peer Review.

1. During the initial step of the Peer Review, the Care Manager reviews the authorization request with the ASO psychiatrist within 24 hours of the authorization request. The ASO psychiatrist will determine if clinical guidelines are met and make an authorization determination, including alternative treatment recommendations.
2. The Care Manager will notify the provider of the determination of the initial authorization request and explain the availability to discuss the Peer Review determination with the ASO Psychiatrist. The provider may take up to four hours to confirm with Magellan the request for a peer-to-peer discussion.
3. The peer-to-peer discussion must be a discussion between the Practitioner or designee and the Psychiatrist Reviewer (PR). The Appeals Coordinator will arrange the peer to peer discussion within one business day of the request for the peer-to-peer discussion.
4. The peer-to-peer discussion must be timely and the provider must have a back-up procedure for situations where the original provider is not available. The designee must be available within one business day.
5. If the provider declines to complete a peer-to-peer discussion or fails to request or schedule the peer-to-peer discussion, the Psychiatrist Reviewer's initial determination is upheld.

The PR will notify the practitioner of the Peer Review decision at the time of the peer-to-peer discussion. Written notification including medical rational for that decision and the authorization or denial number will be sent to the provider within 24 hours of the decision.

Magellan Health Services has 72 hours following the authorization request to complete the entire Peer Review process, including written notification. The PR, using his/her medical judgment, will determine the appropriateness of the admission or continued stay review and provide specific medical rational for the decision. If the PR denies the care at Peer Review, the provider's next step is a Reconsideration Review.

Reconsideration Review

If a PR issues a denial at Peer Review, a Reconsideration Review of that decision is available. A consumer or provider may have up to 90 days of the notification results of the Peer Review to request a Reconsideration Review. The provider can determine the level or urgency of the Reconsideration. If the provider determines that the reconsideration is urgent (i.e., the member is in a 24 hour facility) the reconsideration determination is made within 72 hours of the request for reconsideration. If the provider determines that the level of urgency for the reconsideration is standard (i.e., a request for psychological testing), the determination is made within 14 days of the request for reconsideration. If the provider does not indicate level of urgency, the ASO will process all acute requests within 72 hours and all other requests as a standard reconsideration request and issue a determination with 14 days of the request for reconsideration.

A PR will complete the Reconsideration Review within 30 calendar days of receipt of the request.

The Appeals Coordinator will select a PR not involved in the Peer Review decision to conduct the Reconsideration Review. The client's medical information supplied by the provider and/or supervising practitioner will be provided to the PR who will independently make a decision regarding medical necessity.

Reconsideration Reviews will be completed in writing.

Reconsideration Review PRs can uphold, reverse, or modify the Peer Review denial decision. Written notification including medical rational of that decision and the authorization or denial number will be sent to the provider and/or member within 24 hours of that decision.

A Reconsideration Review must be completed prior to the provider or member requesting a Sate Fair Hearing. The Reconsideration Review process is not available for quality issues and technical denials.

Retrospective Review

If the client discharges pending a Peer Review or Reconsideration Review, the case becomes a Retrospective Review. Retrospective Reviews must be requested in writing and accompanied by the complete medical record within 60 calendar days.

Technical Denial

A technical denial will be issued for admissions that are not authorized prior to or at the time of admission. The day(s) from admission to the date Magellan is contacted are technically denied. Technical denials will be issued for admissions occurring after normal business hours that are not reviewed during the following business day, continued stay reviews that are not done timely, and if the retrospective review is requested more than 60 calendar days. A Reconsideration Review for a technical denial is not available through Magellan Health Services.

Reinstatement

Following a denial, if the client is not discharged and again meets clinical guidelines, the Care Manger will reinstate the authorization from the date the client again met clinical guidelines. It is the responsibility of the facility or supervising practitioner to request a Reinstatement Review.

State Fair Hearing

If a denial is upheld or adversely modified at the Reconsideration Review process, the facility or client/guardian may appeal the Reconsideration Review decision in writing to DHHS within 90 calendar days from the date of the Reconsideration Review denial letter.

NOTE: For additional Appeal Process information see Appendix (I).

Age Waiver for Adult Services

The age waiver procedure is available to 18 year old Nebraska residents who have medical necessity and are developmentally appropriate for an adult service and do not have Medicaid or other insurance coverage. An underage exception for those meeting clinical guidelines can be arranged by a care manager in conjunction with approvals from the Regional Administrator and Behavioral Health Division administrator.

1. Call Magellan and do an initial clinical review for the service. Make sure to include information regarding the youth's developmental readiness for an adult program. If it is a Substance Abuse service, please provide us with the recommendations from a SA evaluation by a LADAC.

2. Contact the appropriate Regional Administrator to gain approval for funding.

3. Fax a letter to the designated Division of Behavioral Health and to Magellan staff containing; Magellan's determination; the Region's decision on funding; and the program's ability to meet the youth's treatment and developmental needs.

4. Once the Division of Behavioral Health approves the age waiver, the Magellan care manager who you originally completed the initial review with will call you back with an authorization.

Coordinating Care and Joint Treatment Planning for Transition Age Youth

Magellan care management staff offer clinical case conferences to review joint treatment plans for transition age youth. This service is offered to the Regions, state case workers, and guardians to ensure that all possible appropriates services and referrals are considered for youth eighteen to twenty one years old. To access this service please call the Magellan Nebraska CMC.

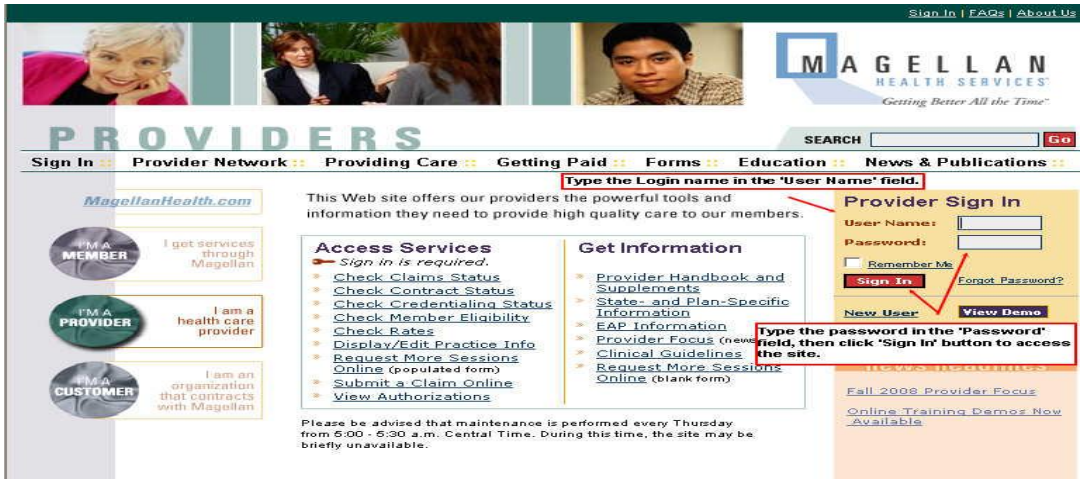
Technical Requirements

- Pentium 200 PC, 32 mb RAM or better.
- Internet Explorer (IE) browser Version 6.0 or higher; or Netscape browser Version 4.0 or higher. **Based on internal design and testing the aforementioned browsers work best with this application. Other browsers such as FireFox have had compatibility issues reported.**
- Internet Access (Broad Band preferred).

Login

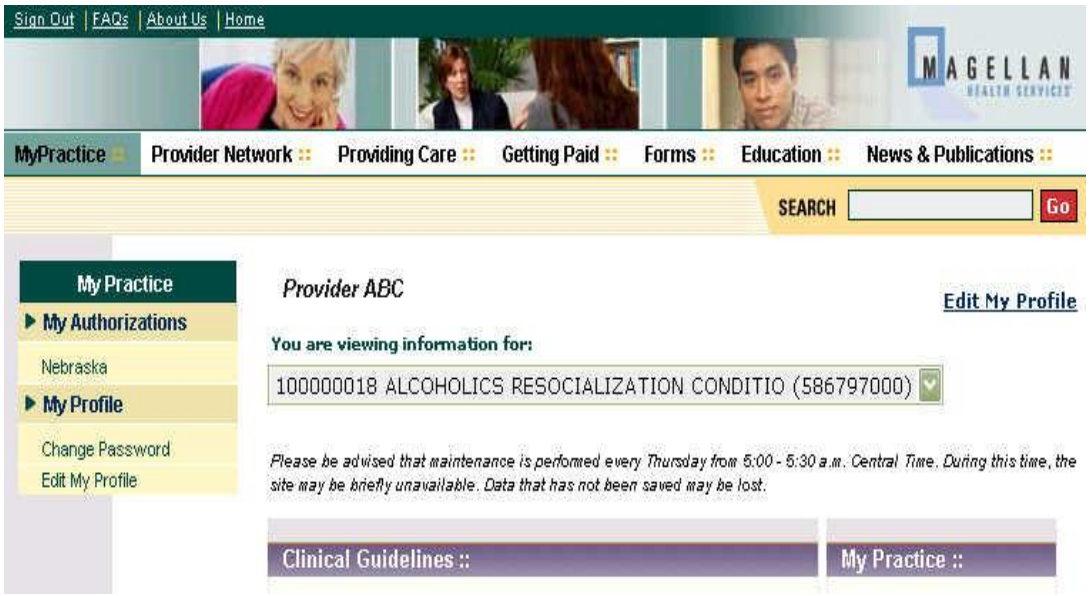
To access the application:

- Go to www.Magellanprovider.com/provider.
- Sign in with your secure User Name and Password (see screen shot below).
- Each entity requires a separate User Name and Password. Please keep the entity password secure to prevent unauthorized persons from accessing Nebraska information. Remember, this information is patient sensitive.
- Providers are allowed three (3) attempts to login correctly. **After 3 unsuccessful attempts, the login account will be locked.** Contact the Magellan Nebraska CMC to have the login account reset and a new password issued.



General Nebraska Website Information

Click the Nebraska link on the left menu of the Welcome Page.



Select one of the following (see screen shot below):

1) New Registration to begin a registration admission on a member.

2) New Registration From Existing to find an existing registration for a member that needs to be registered or pre-authorized for another service. This acts as a 'copy' feature.

3) Edit Registration to edit data for a member's registration – i.e.: last name, address, phone number, etc. Please note that an individual's SSN cannot be changed by the user. In the event an incorrect SSN is entered, contact the Magellan Nebraska CMC to have it corrected.

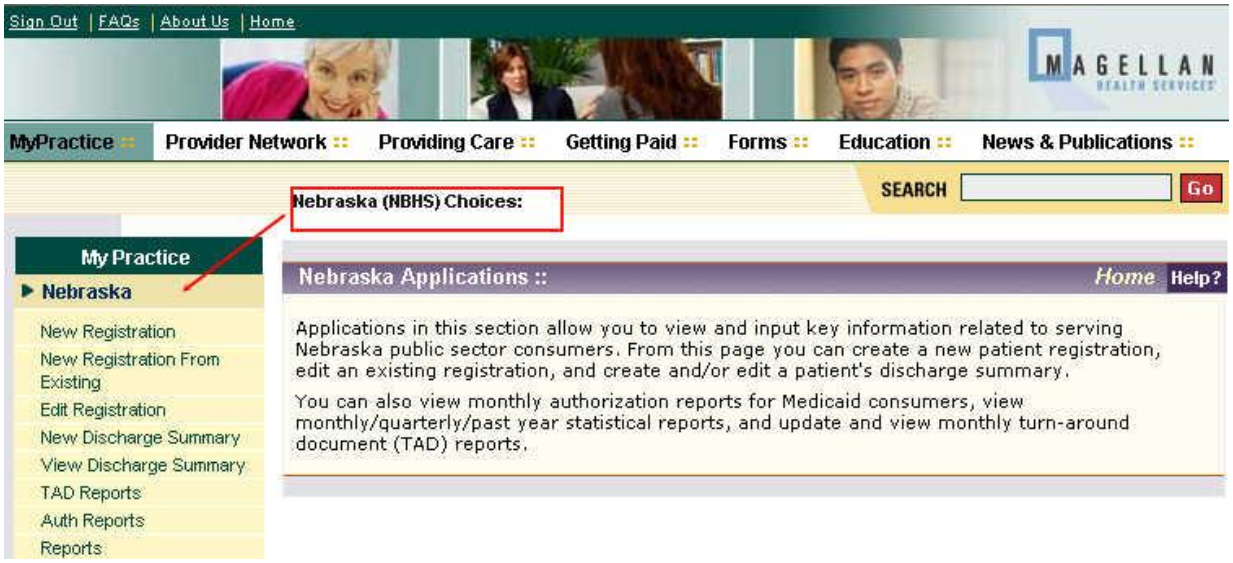
4) New Discharge Summary to discharge a member's registration.

5) View Discharge Summary to view a completed discharge. Please note: Once the member has been discharged, you will no longer be able to edit any data within the application.

6) TAD Reports will allow you to review registration and authorization data as well as enter unit of service information (encounter data).

7) Auth Reports will allow you to view authorization details including authorized treatment units by CPT codes, days authorized and the Medicaid authorization number for the Medicaid Rehabilitation Option (MRO) and Adult Substance Abuse (ASA) services authorized to Medicaid eligible consumers.

8) Reports provide consumer service data in summary detail by provider see Appendix (II).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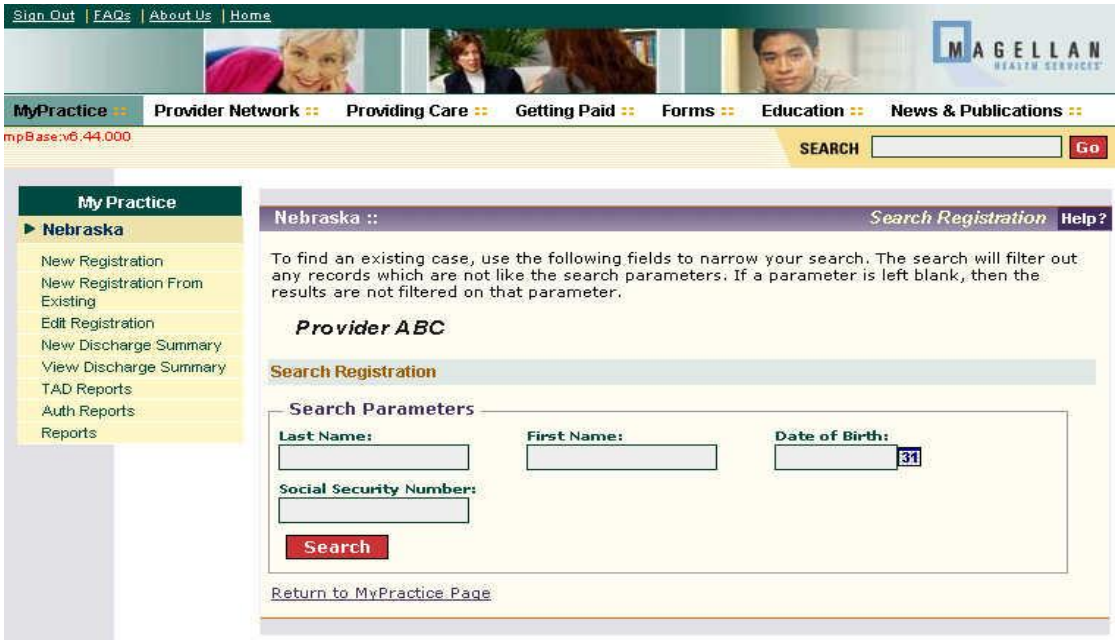
HEALTH SERVICES
MyPractice :: Provider Network :: Providing Care :: Getting Paid :: Forms :: Education :: News & Publications ::
SEARCH Go
Nebraska (NBHS) Choices:
My Practice
Nebraska
New Registration
New Registration From Existing
Edit Registration
New Discharge Summary
View Discharge Summary
TAD Reports
Auth Reports
Reports
Nebraska Applications ::
Home Help?
Applications in this section allow you to view and input key information related to serving Nebraska public sector consumers. From this page you can create a new patient registration, edit an existing registration, and create and/or edit a patient's discharge summary.
You can also view monthly authorization reports for Medicaid consumers, view monthly/quarterly/past year statistical reports, and update and view monthly turn-around document (TAD) reports.

Consumer Registration Process (Getting Started)

1) Search Screen: After selecting "New Registration", the provider will be prompted with a Search Registration page where they will enter the parameters to be searched. You can do a search using the following three elements:

   - O **Last Name**: Enter the Consumer's Last name.
   - O **First Name:** Enter the Consumer's First name.
   - O **Date of Birth:** Enter the Consumer's Date of Birth if known in the format of MM/DD/CCYY. (Or you can search by SSN only)
   - O **Social Security Number:** If you use the SSN, it is the only required field with this search screen. Enter the consumer's Social Security number. It must be a nine (9)-digit number. For best results search by the SSN only.



2) Registration Does Not Exist: If the Provider conducts a search and no results are returned, they will get a link at the bottom of the page that says "Registration does not exist. Please add new registration OR register client at another location." The Provider will need to add a new registration for this member by clicking on that link (see example below).

3) Registration Already Exists: If the consumer already exists in the system, a link listing the consumer's name and service(s) will be displayed. The provider can click on the displayed name link and verify the information on the electronic registration form.

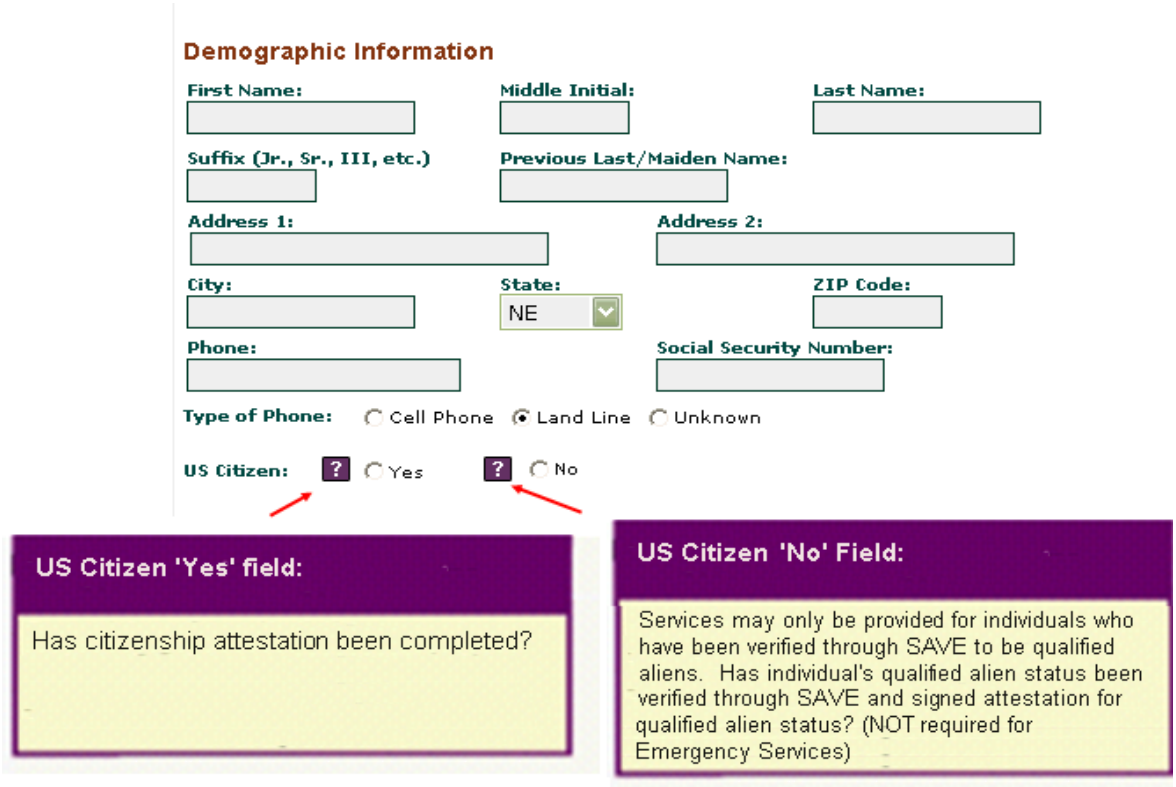
New Registration Page (1):

After selecting the "Registration does not exist" link, the provider will be taken to the first page of the four page registration to enter the required data to start a case with Magellan. The first page will ask the provider to complete the following sections:

Demographic Information This section contains consumer identifying information and includes the fields listed below and as illustrated in the screen shots that follows.

Please note: data that can be entered as text are illustrated in the screen shots. Data that can be entered with a "Radio Button" are also shown in that manner. Data that requires the use of a "Drop Down Box" have the available choices reflected in the boxed figures under each data element.

- **First Name**
- **Middle Initial (Optional field)**
- **Last Name**
- **Suffix (Jr., Sr., III, etc.)**
- **Previous Last/Maiden Name**
- **Address** (Street, City, State & Zip) - For consumers that are homeless persons and others with no permanent address enter 'No Permanent Address' in the Street field and complete the City and Zip Code based on the current service location.
- **Phone Number** (If unknown, use area code known, then 999-9999 as default). Do not use parenthesis around the area code or dashes between the numbers. This field is auto-formatting.
- **Type of Phone** (cell phone/land line/unknown)
- **Social Security Number** – Enter the consumer's nine digit social security number. If the consumer is a qualified alien and does not have an SSN, enter the person's Alien ID number with sufficient zeros at the end to make it a nine digit number.
- **US Citizen (Yes/No)** - Please see the hover text available for this field to clarify how to respond to this field.



O **Marital Status** - Select the consumer's marital status from the drop down menu:

Cohabitating	Never Married
Divorced	Separated
Married	Widowed

O **Race** - Select the consumer's race (all that apply) from the choices below:

American Indian	Native Hawaiian
Asian	Other Pacific Islander
Alaska Native	White
Black American	

O **Ethnicity** - Select the consumer's race from the drop down menu:

Cuban	Other Specific Hispanic
Hispanic (Specific Origin Unknown)	Puerto Rican
Mexican	Unknown
Not of Hispanic Origin	

O **Preferred Language** - Select the consumer's preferred language from the drop down menu:

Arabic	Italian	NA Umohon
Chinese	Japanese	Neur
English	Korean	Portuguese
Farsi	Laotian	Russian
French	NA Dakota	Sign Language
German	NA Ho-Chunk	Spanish
Hebrew	NA Lakota	Tagalog
Hindi	NA Ponca	Vietnamese

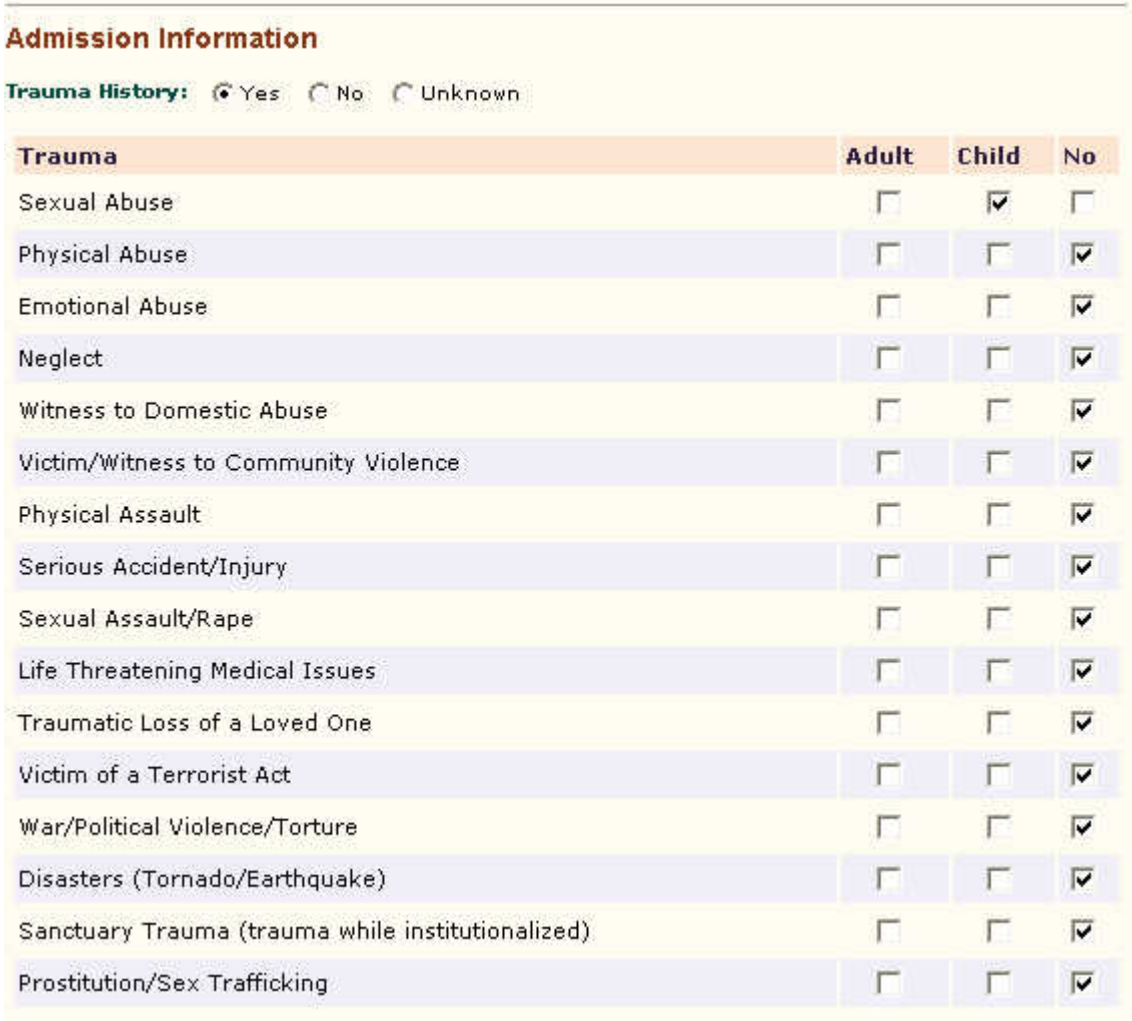
O **Gender (Male/Female)** - Select the consumer's gender with the radio buttons.

O **Veteran Status (Yes/No**) - Select the consumer's veteran status with the radio buttons.

O **Disability (select all that apply**) - Select the consumer's disability status from the multi-select boxes. Please refer to hover text for guidance.

Admission Information: This section obtains additional client information related to the consumer's admission.

O **Trauma History** - In order to support Trauma Informed Care the consumer's experience with trauma needs to be evaluated. If the Provider clicks 'Yes' to the Trauma History field, an accordion view of several Trauma types will display. Providers then need to enter at least one type of trauma the consumer reports experiencing, as well as when it occurred i.e., either as a Child or as an Adult. Any traumas not reported by the consumer are entered as "No".



Admission Information

Trauma History: (•) Yes ( ) No ( ) Unknown

Trauma	Adult	Child	No
Sexual Abuse	☐	☑	☐
Physical Abuse	☐	☐	☑
Emotional Abuse	☐	☐	☑
Neglect	☐	☐	☑
Witness to Domestic Abuse	☐	☐	☑
Victim/Witness to Community Violence	☐	☐	☑
Physical Assault	☐	☐	☑
Serious Accident/Injury	☐	☐	☑
Sexual Assault/Rape	☐	☐	☑
Life Threatening Medical Issues	☐	☐	☑
Traumatic Loss of a Loved One	☐	☐	☑
Victim of a Terrorist Act	☐	☐	☑
War/Political Violence/Torture	☐	☐	☑
Disasters (Tornado/Earthquake)	☐	☐	☑
Sanctuary Trauma (trauma while institutionalized)	☐	☐	☑
Prostitution/Sex Trafficking	☐	☐	☑

O **Date of Birth** - Enter in the format MM/DD/CCYY. Double check the date entered to insure accuracy.

O **Age at Admission** - This field is auto-calculated based on birth date entered in the Date of Birth field. (Provider only needs to “tab” over to this field for the age to be auto-calculated).

O **County of Residence** - Select the County from the drop down menu that is the consumer's County of Permanent Residence. NOTE: This is basically the answer to the question, "Where do you live?" This is the Name of the County where the consumer has established residency within the State of Nebraska. In general, it is the county where the person has established his or her permanent and principal home, and to which, whenever he or she is absent, he or she has the intention of returning.

It is officially the "county of residence" if the person has resided one year continuously in that county. If the person has resided one year continuously within the state, but not in any one county, then he/she's county of legal residence is in the county in which he or she has resided six months continuously. (Neb. Rev. Stat. §68-115 – Legal settlement, defined)

If "County of Residence" at Admission is UNKNOWN, the default reporting is the same as "County of Admission".

If a person is homeless at Admission, the default reporting is the same as "County of Admission".

O **County of Admission** - Select the County from the drop down menu that is the County where the program the consumer is admitted to is located. **NOTE**: County of Admission is the county from which the individual was admitted, regardless of where she/he maintains her/his residence.

Financial Information - This section obtains financial information related to the consumer and contains the following fields:

O **Number of Dependents** – Enter the number of persons that are dependent on the consumer. Enter (00) for no dependents (as in the case of a child) or for "self" if the consumer has no dependents.

O **Annual Gross Income (nearest $1,000)** - Enter the consumer's annual gross income rounded to the nearest $1,000 (do not enter decimals, commas, or dollar signs).

O **SSI/SSDI Eligibility** – Select the consumer's eligibility status for SSI/SSDI from the drop down menu:

Det. to Be Inelig-NA	Elig/Recv. Payments
Elig/Not Recv. Benefits	Potential. Eligible

O **Medicaid/Medicare** - Select the consumer's eligibility status for Medicaid/Medicare from the drop down menu:

Det. to Be Inelig-NA	Elig/Recv. Payments
Elig/Not Recv. Benefits	Potential. Eligible

O **Health Insurance** - Select the consumer's health insurance coverage from the drop down menu:

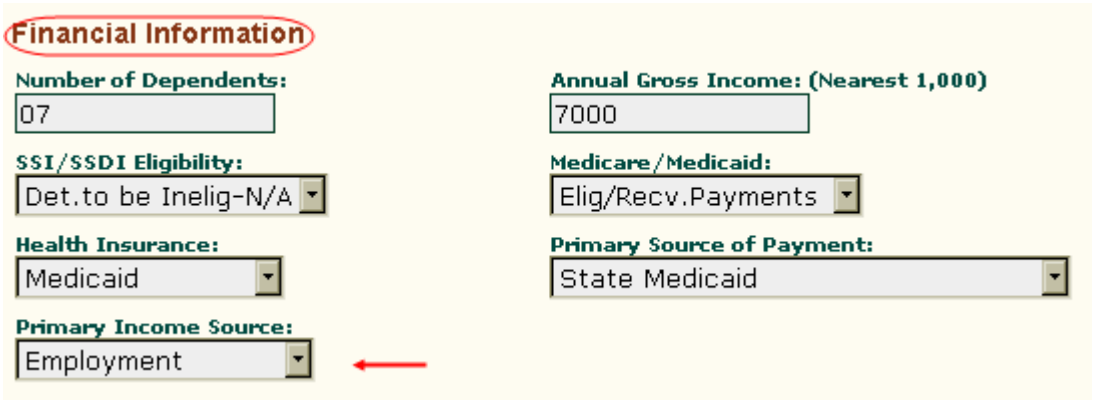
Child Welfare	Medicare	Other Direct Sta
HMO	No Insurance	PPO
Indian Hlth Svc.	Other Insurance	Priv. Self Paid
Medicaid	Other Direct. Fed.	Veterans Admin

O **Primary Source of Payment** - Select the primary source of payment for the services the consumer will be receiving as a result of this registration/pre-auth:

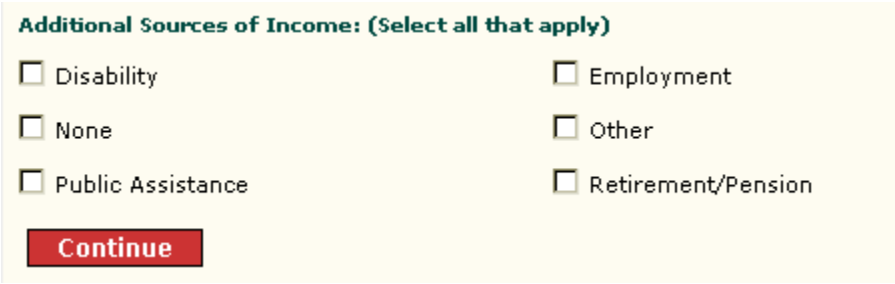
Blue Cross/Blue Shield	Private Hlth Insurance	State Medicare
Employee Assistance (EAP)	Self Pay	Unknown
HMO/PPO	State Beh Hlth Funds	Workers Compensation
No Charge	State Child & Fmly Svcs	
Other Source	State Medicaid	

O **Primary Income Source** – Select the consumer's primary source of income from the drop down menu:

Disability	Other
Employment	Public Assistance
None	Retirement/Pension



O **Additional Sources of Income (Select all that apply)** – Select any additional sources of income the consumer may report from the multi-select boxes as indicated in the screen shot below:



Click 'Continue' at the bottom of this screen to proceed to Page (2) of the registration process and continue to enter the required data to start a case with Magellan.

New Registration Page (2):

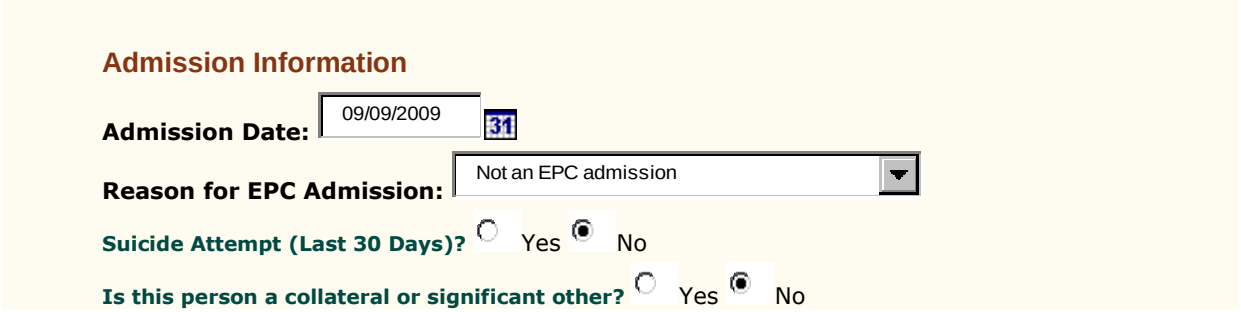
- **Admission Date** - Enter the consumers date of admission using the format DD/MM/YYYY. You can also use the pop-up calendar to select the admission date.

- **Reason for EPC Admission** - Select the appropriate admission reason from the drop down menu.

Both Dangerous to Self and Others
Dangerous to Others
Dangerous to Self/Neglect
Dangerous to Self/Suicide Attempt
Not an EPC Admission

- **Suicide Attempt (Last 30 Days** - Select from the Radio Buttons (Yes/No) if there was a suicide attempt on the part of the consumer within the last 30 days prior to admission.

- **Is this Person a Collateral or Significant Other** - Select from the Radio Buttons (Yes/No) if the person being admitted is a Collateral or Significant Other.



Medical Status - The following information will be requested if the Consumer is identified as a female on the previous screen:

- **Is the Consumer Pregnant** - Select from the Radio Buttons (Yes/No/Up to 6 Weeks Post Partum) if the person being admitted is pregnant.

Socioeconomic Indicators

O **Living Situation** - Select from the drop down menu the choice that describes the consumer's current living situation. See Appendix (III) for definitions of each living situation.

Child Liv. w/Par/Rela	Jail/Correct. Facil.	Priv. Res. Recv. Suprt.
Child Resident. Treat	Oth. 24 Hr Res. Care	Priv. Res. w/o Support
Crisis Resident. Care	Oth. Insti. Setting	Regional Center
Foster Home	Other	Residential Treatment
Homeless/HL Shelter	P Res w/ Housing Asst	Youth Liv. Independ.

O **Education** - Select the highest educational level completed by the consumer at the time of admission from the drop down menu.

First Grade	Seventh Grade	> 12 Years
Second grade	Eighth Grade	Associated Degree
Third Grade	Ninth Grade	Bachelors Degree
Fourth Grade	<= 10 Years	Masters
Fifth Grade	11 Years	Doctorate
Sixth Grade	12 Years = GED	Unknown

O **Employment Status** - Select the consumer' employment status at the time of admission from the drop down menu.

Active Armed Forces (35 + Hrs)	Resident of Institution	Unemployed (Not seeking)
Active Armed Forces (< 35 Hrs)	Retired	Volunteer
Disabled	Sheltered Workshop	
Employed Full Time (35 + Hrs)	Student	
Employed Part Time (< 35 Hrs)	Supported Employment	
Homemaker	Unemployed (Laid off/Looking)	

O **Meets Nebraska SED Criteria** - Select from the Radio Buttons (Yes/No) if the consumer meets the Nebraska SED criteria as defined in Appendix (IV) of this manual.

O **Meets Nebraska SPMI Criteria** - Select from the Radio Buttons (Yes/No) if the consumer meets the Nebraska SPMI criteria as defined in Appendix (IV) of this manual.

Adolescents – Please note this section will not appear on the admission screen if the consumer's date of birth on Pg (1) indicates the consumer is more than 19 years old at the time of admission.

O **School Attendance (Last Six Months)** - Select from the drop down menu the choice that best reflects the consumer's attendance at school during the six months prior to admission.

1 Day Every 2 Weeks	1 or Less Days/Month	Home Schooled
1 Day Per week	2 or More Days/Week	Not Enrolled

O **Stable Environment (Legal Custody**) - Select from the drop down menu the choice that best reflects the consumer's legal custody status at the time of admission.

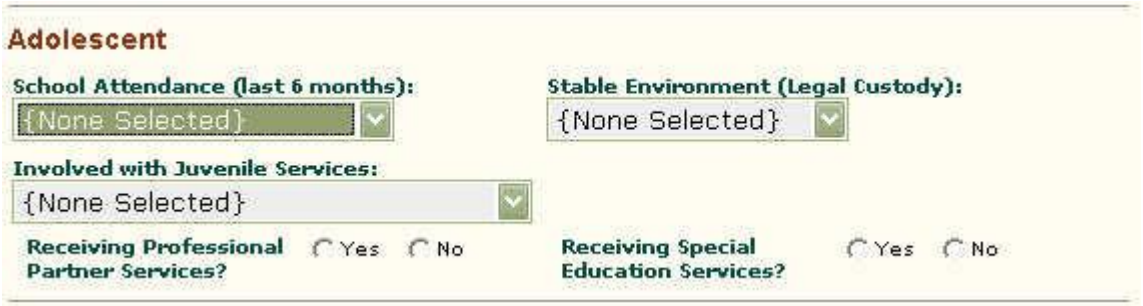
Emancipated Minor	Parent(s)
Guardian	Ward of the State

O **Involvement with Juvenile Services** - Select from the drop down menu the choice that best reflects the consumer's involvement (if any) with Nebraska Office of Juvenile Services (OJS) at the time of admission.

Drug Court	Other Court Involvement
Not Involved with Juvenile Services	Probation
OJS State Ward	

O **Receiving Professional Partner Services** - Select from the Radio Buttons (Yes/No) if the consumer is receiving Professional Partner Services.

O **Receiving Professional Partner Services** - Select from the Radio Buttons (Yes/No) if the consumer is receiving Special Education Services.



Service Treatment

O **Admission Referral Source** – Select from the drop down menu the source of the consumer's referral for this admission

Agricultural Action Center	Mental Health Commitment Brd.	Private SA Provider
Alanon/Alateen/Etc.	Mental Health Court	Probation
Clergy	Mental Health Emergency	Prosecutor
Community Service Agency	Mental Health Non-Residential	Public Health Staff
Compulsive Gambling Prov.	Mental Health Residential	Regional Center
Corrections	Mental Retardation Agency	SA Emergency/Detox.
County Extension Agent	Mid-Level Practitioner	SA Halfway House
Court Order	Nursing Facility	SA Methadone Detox.
Court Referral	Obsolete – SA Meth. Maint.	SA Outpatient Counseling
Defense Attorney	Obsolete – SA Partial Care	SA Prevention
Drug Court	Obsolete – Profess. Intervent.	SA Self-help Group
Employee Assistance Prgm.	Obsolete – Profess. Supt. Grp.	SA Short-term Residential
Employers	Other Human Service Provider	SA Therapeutic Comm.
Family	Other Medical Facility	School Based Referral
Helpline	Parole	Self
Food Pantry	Police	Services Psychiatric Eval
Friend	Pre-trial Diversion	Soc. Svc. Sexual Perp. Eval
Homeless/Shelter	Private Family Counselor/Agenc.	State Social Service
Hospital	Private Mental Hlth. Prac.	Tribal Elder or Official
Job Training Office	Private Physician	Veteran's Administration

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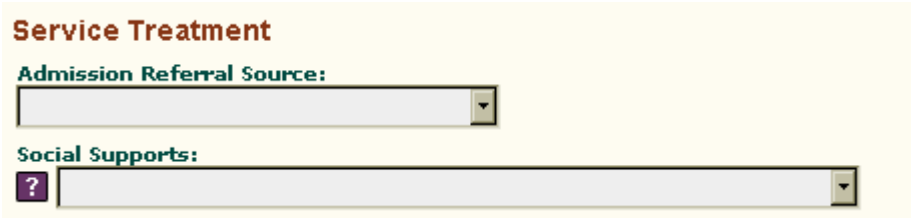
O **Social Supports** - Select from the drop down menu (see table below) the best description of the consumer's Social Supports at the time of Discharge. Refer to the Hover Text for a definition of Social Supports by placing the cursor over the (?) next to this field.

No attendance in the past month
1-3 times in the past month (less than once per week)
4-7 times in the past month (about once per week)
8-15 times in the past month (2 or 3 times per week)
16-30 times in the past month (4 or more times per week)
Some attendance in the past month, but frequency unknown)



Legal Status

O **Legal Status at Admission** - Select from the drop down menu the choice that describes the consumer's legal status at the time of admission.

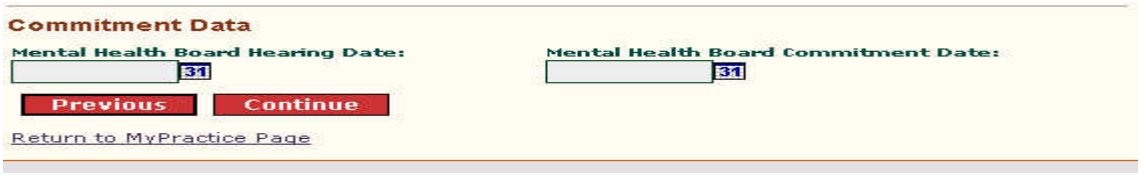
Civil Protective Custody (CPC)	MHB Commitment
Court Order	MHB Hold/Custody Warrant
Court: Competency Evaluation	Not Responsible by Reason of Insanity
Court: Juvenile Commitment	Parole
Court: Juvenile Evaluation	Probation
Court: Mentally Disordered Sex Offender	Voluntary
Court: Presentence Evaluation	Voluntary by Guardian
Emergency Protective Custody (EPC)	
Juvenile High Risk Offender	

O **Number of Arrests in the Past 30 Days** – Enter in the "text field" the number of arrests the consumer has had in the thirty days prior to admission. Enter (00) if none.

Commitment Data

O **Mental Health Board Hearing Date** – Enter the date in the "text field" using the format DD/MM/YYYY of the consumer's Mental Health Board Hearing date (leave blank if not applicable). Update the Hearing Date field as appropriate following Admission.

O **Mental Health Board Commitment Date** – Enter the date in the "text field" using the format DD/MM/YYYY of the consumer's Mental Health Board Commitment date (leave blank if not applicable). Update the Commitment Date field as appropriate following Admission.



New Registration Page (3):

Substance Abuse

O **Reason for this Admission** - Select from the drop down menu the choice that describes the reason for the consumer's current admission.

Dual Diag./Prim. MenHlth/Prim. SA	Prim. SA/Secondary Mental Hlth
Prim. Compulsive Gambling	Prim. Sex Offender
Prim. Mental Hlth/Secondary SA	Primary Mental Health
Prim. Mental Retardation	Primary Substance Abuse

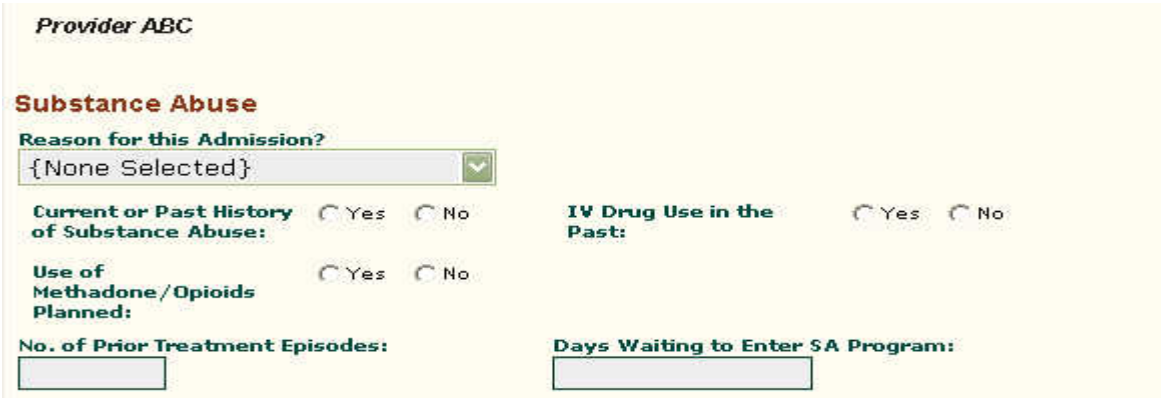
O **Current or Past History of Substance Abuse** - Select from the Radio Buttons (Yes/No) whether or not the consumer has a past history of substance abuse.

O **IV Drug Use in the Past** - Select from the Radio Buttons (Yes/No) whether or not the consumer has a past history of IV Drug Use.

O **Use of Methadone/Buprenorphine/Suboxone/Opioids in Treatment Plan** - Select from the Radio Buttons (Yes/No) whether or not the use of Opioid replacement therapy is included as part of the consumer's current treatment plan.

O **Number of Prior Treatment Episodes** – Enter a two digit number in the "text field" corresponding to the number of prior mental health and/or substance admissions the consumer has had prior to this admission. If none enter (00).

O **Days Waiting To Enter SA Program** - Enter up to a three digit number in the "text field" corresponding to the number of days the consumer has waited to enter a substance abuse treatment program. If none enter (000). Place the cursor over the (?) next to this field for further definition regarding this question.



Substances Used

If any of the answers to the above questions regarding substance abuse history IV drug use, or use of Methadone/Buprenorphine/Suboxone/Opioids in the consumer's treatment plan are "Yes", then additional information concerning the substance(s) used must be provided.

For each of the Primary, Secondary, or Tertiary substances used, please complete the following information. If only a Primary Substance of use is reported you must select "Not Applicable" in the "Name" field of the Second and Third Substance in order to complete this section. If only a Primary and Secondary Substance of use is reported you must select "Not Applicable" in the "Name" field of the Third Substance in order to complete this section.

O **Name of Substance** - Select from the drop down menu the name of the substance used. These are presented alphabetically in the drop down.

O **Age of First Use** - Enter a two digit (00-99) number in the "text field" corresponding to the age when the consumer began using the substance.

O **Frequency** - Select from the drop down menu the choice that best describes the consumer's frequency of use. If "Other" is selected a "pop-up" box is presented for an up to 20 character text description.

1 – 2x's past week	Daily	Unknown
1 – 3x's past month	No use past month	
3 – 6x's past week	Other	

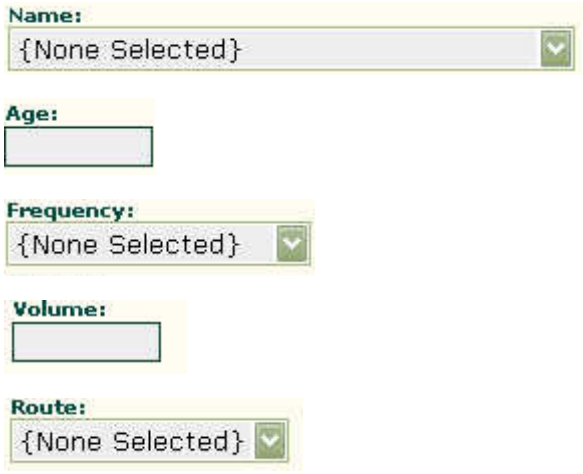
O **Volume** - Enter in the "text field" an up to (20) character description of the volume of the substance used.

O **Route** - Select from the drop down menu the choice that describes the route the consumer used to ingest the substance.

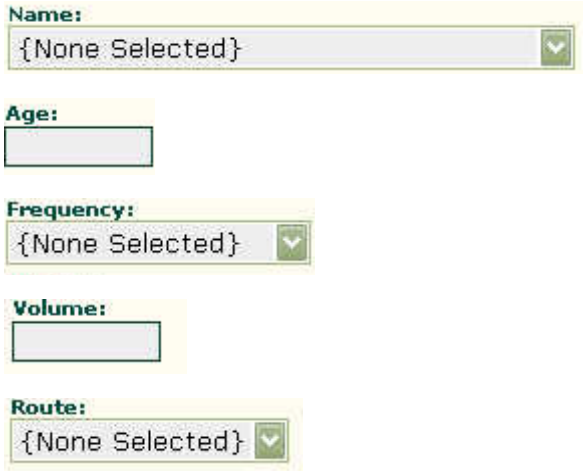
IV	Oral	Smoke
Nasal	Other	Unknown

Primary Substance/Second Substance/Third Substance (this set of fields appears for each of the three substances on the web screens).

Primary Substance



Second Substance



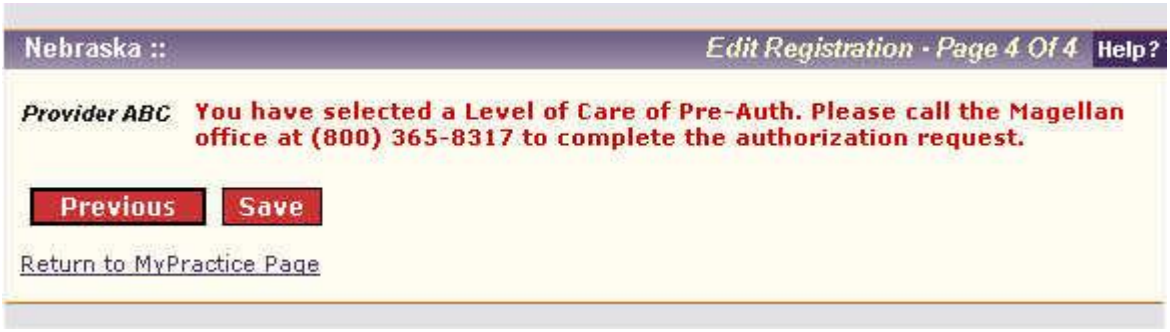
Third Substance

Level of Care

This field is used to select the service for which the consumer is to be registered or pre-authorized (see note below). Select one service type from the drop down menu. Note: Services with the (Ch) pre-fix are children's services. Do not select these service types to register or pre-authorize an adult.

Assess/Eval Only – MH	Crisis I/P – Youth
Assess/Eval Only – SA	Day Support
Assess/Eval Only – Justice	Detox
CPC	EPC
Ch Day Treatment	Emer Psych Obs 23:59
Ch Halfway House	Emergency Comm Supp
Ch Home Based MST	Family Navigator
Ch IOP –SA	Int Case Mngt – MH
Ch Med Management	Int Case Mgnt – SA
Ch O/P – MH	Medication Management
Ch O/P - SA	OpiodRplace - MethBup
Ch Ther Community	O/P Dual Dx
Ch Partial	O/P – MH
Ch Prof Part School	O/P – SA
Ch Prof Partners	Pre-Auth (See note below)
Ch Yth Assess Only – MH	Psych Respite
Ch Yth Assess Only – SA	Psychological Testing
Ch Respite	Recovery Support
Crisis Assess/Eval – MH	Supported Employment
Crisis Stabilz/Tx	Supported Living
Crisis Assess LDAC – SA	

Please note: The option 'Pre-Auth' is for Authorized Services. If this is selected, the user will receive the message in the screen shot below. The additional fields necessary for an authorization must be completed telephonically with a Magellan Care Manager and the web-based process concludes at this point. For Registered services proceed to page (4).



New Registration Page (4):

Diagnosis

O **Date of Diagnosis** – Enter the consumer's most recent Date of Diagnosis in the format DD/MM/YYYY. You can also use the pop-up calendar to select the admission date.

O **Diagnosis Codes Axis I** – Select up to four Axis I codes from the drop down menu. The codes are presented in alphabetical order in the drop down menu. At least one Axis I code must be selected. If there is no is no Axis I diagnosis select "V71.09 No Diagnosis on Axis I or II" in the Axis I (A) field.

O **Diagnosis Codes Axis II** – Select up to four Axis II codes from the drop down menu. The codes are presented in alphabetical order in the drop down menu. At least one Axis II code must be selected. If there is no is no Axis II diagnosis select "V71.09 No Diagnosis on Axis I or II" in the Axis II (A) field.

O **Diagnosis Codes Axis III** – Enter up to four Axis III codes in the text fields. These fields are used to report any physical health issues the consumer reports having. At least one Axis III code must be entered. If there is no is no Axis III diagnosis enter "None Reported" in the Axis III (A) field.

O **Diagnosis Codes Axis IV** – Select as many Axis IV conditions from the multi-select boxes as apply. At least one Axis IV condition must be entered from the following choices:

- Diagnosis Condition Deferred
- Problems with access to health care services
- Economic Problems
- Problems with Primary Support Group
- Educational Problems
- Problems related to interaction with the legal system/crime
- Housing Problems
- Problems related to the social environment
- Occupational Problems
- Other Psychosocial and Environment Problems

O **Diagnosis Codes Axis V GAF** – This field is a text box for the user to enter a numeric value from 1 -100 to record the consumer's current Global Assessment of functioning (GAF) Score.

Date Of Diagnosis

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Diagnosis Codes

Axis I:

Axis I (A):
{None Selected}

Axis I (B):
{None Selected}

Axis I (C):
{None Selected}

Axis I (D):
{None Selected}

Axis II:

Axis II (A):
{None Selected}

Axis II (B):
{None Selected}

Axis II (C):
{None Selected}

Axis II (D):
{None Selected}

Axis III:

Axis III (A):

Axis III (B):

Axis III (C):

Axis III (D):

Axis IV:

Axis IV:

- ☐ Diagnosis Condition Deferred
- ☐ Economic Problems
- ☐ Educational Problems
- ☐ Housing Problems
- ☐ Occupational Problems
- ☐ Problems with access to health care services
- ☐ Problems with Primary Support Group
- ☐ Problems related to interaction with the legal system/crime
- ☐ Problems related to the social environment
- ☐ Other Psychosocial and Environment Problems

Axis V GAF (Current):

Saving Your Work

Be sure to click on the SAVE button at the bottom of registration Page (4) after you have entered the GAF Score. This will complete the online registration process. If your submission was successful you will see the message below.

Submission Complete

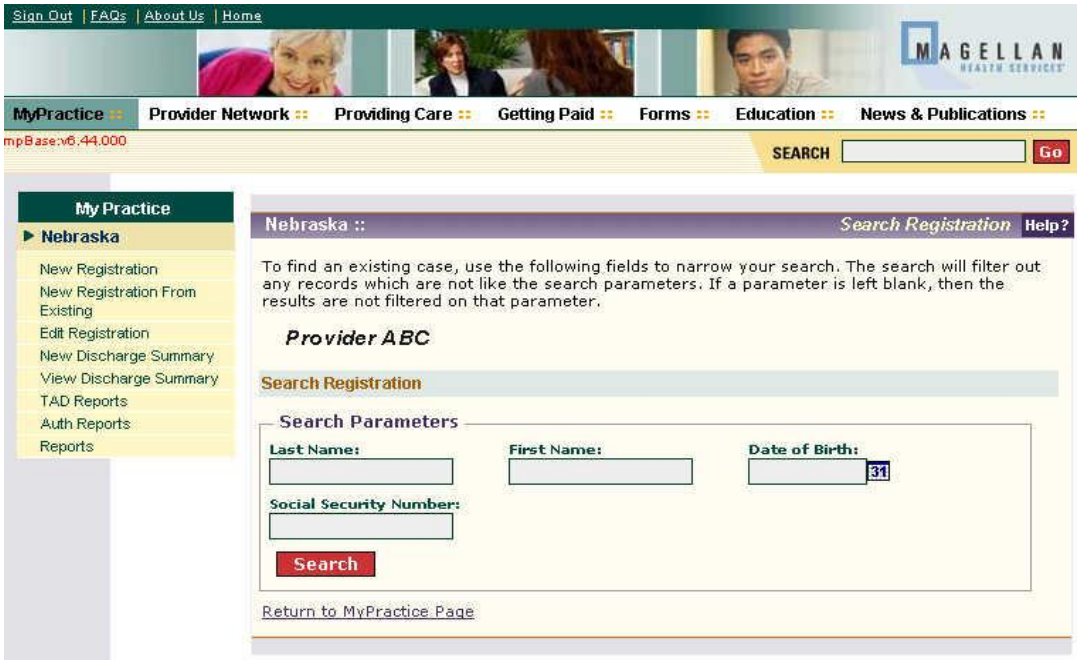
Your request has been successfully saved.

Return to MyPractice Page

Consumer Discharge Process

1) Search Screen: After selecting "New Discharge Summary", the provider will be prompted with a Search Registration page where they will enter the parameters to be searched. You can do a search using the following three elements:

- O **Last Name**: Enter the Consumer's Last name.
- O **First Name**: Enter the Consumer's First name.
- O **Date of Birth**: Enter the Consumer's Date of Birth if known in the format of MM/DD/CCYY. (Or you can search by SSN only)
  If you use the SSN, it is the only required field with this search screen. Enter the consumer's Social Security number. It must be a nine (9)-digit number. For best results search by the SSN only.



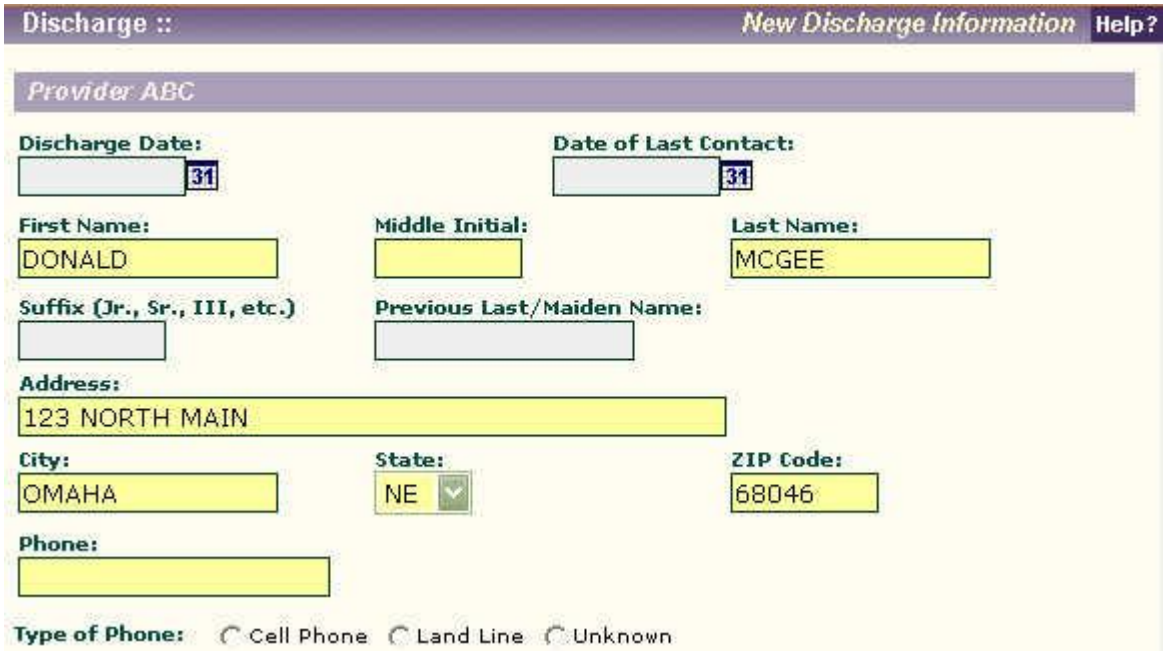
2) Search Results: After entering the search parameters all the services that the consumer has received that are not discharged will be returned. Each service will have a link for selection. Chose the service that is to be discharged and click on the associated link. The "New Discharge" screen will appear. Note: When discharging a re-registration discharge only the most recent one as distinguished by the most recent Admission date.

- O **Discharge Date** - Enter the date of discharge for the consumer in MM/DD/CCYY format or use the date selector (calendar icon) to select a date.

- O **Date of Last Contact** - Enter the Date of Last Contact for the consumer in MM/DD/CCYY format or use the date selector (calendar icon) to select a date. This date may be different from the discharge date. This is the last date of service from the service agency and does not include attempts to contact the consumer by agency personnel to set up additional service contacts. For single time episodes this may be the same as the admission date.

The following fields will be pre-populated on the Discharge screen from the Registration information obtained at admission. Review and update as necessary:

- First Name
- Middle Initial
- Last Name
- Suffix
- Previous Last/Maiden Name
- Address/City/State/Zip
- Phone Number - This field DOES NOT pre-populate, and will need to be re-entered at discharge.
- Type of Phone - This field DOES NOT pre-populate, and will need to be re-entered at discharge.



O **Discharge Status** - Select from the drop down menu the choice that describes the consumer's status at Discharge.

Chose to decline additional Tx	Terminated by Facility
Client seen for Assess Only/ 1x Contact	Transferred to Another Service
Death, not Suicide	Trans to Another SA Tx Prgm - Did not Report
Death, Suicide Completed	Trans to Another SA Tx Prgm
Incarcerated	Treatment Completed
Left Against Prof Advice (Drop Out)	Unknown
Other	

O **Legal Status** - Select from the drop down menu the choice that describes the consumer's legal status at the time of Discharge.

Civil Protective Custody (CPC)	Juvenile High Risk Offender
Court Order	MHB Commitment
Court: Competency Evaluation	MHB Hold/Custody Warrant
Court: Juvenile Commitment	Not Responsible by Reason of Insanity
Court: Juvenile Evaluation	Parole
Court: Mentally Disordered Sex Offender	Probation
Court: Presentence Evaluation	Voluntary
Emergency Protective Custody (EPC)	Voluntary by Guardian

O **Mental Health Board Disposition** - Select from the drop down menu the choice that describes any Mental Health Board actions (if applicable).

90 Day Suspension	MHB Discharged
Discharge with no hold	No MHB Commitment
MHB Commitment	Transfer prior to legal disposition

O **Destination at Discharge** - Select from the drop down menu the choice that describes the consumer's destination at discharge.

Hastings Regional Center	Norfolk Regional Center
Jail/Correction Facility	Other
Lincoln Regional Center	SA Intensive Res (Ther Comm)
MH Inpatient	SA Outpatient
MH Outpatient	SA Residential (Halfway House)
MH Residential	SA Short Term Residential
Medical	

O **Employment Status** - Select the consumer' employment status at the time of Discharge from the drop down menu.

Active Armed Forces (35 + Hrs)	Homemaker	Supported Employment
Active Armed Forces (< 35 Hrs)	Resident of Institution	Unemployed (Laid off/Looking)
Disabled	Retired	Unemployed (Not seeking)
Employed Full Time (35 + Hrs)	Sheltered Workshop	Volunteer
Employed Part Time (< 35 Hrs)	Student	

O **Living Situation** - Select from the drop down menu the choice that describes the consumer's living situation at the time of Discharge. Refer to Appendix (III) for definitions of the Living Situation types.

Child Liv. w/Par/Rela	Jail/Correct. Facil.	Priv. Res. Recv. Suprt.
Child Resident. Treat	Oth. 24 Hr Res. Care	Priv. Res. w/o Support
Crisis Resident. Care	Oth. Insti. Setting	Regional Center
Foster Home	Other	Residential Treatment
Homeless Shelter	P Res w/ Housing Asst	Youth Liv. Independ.

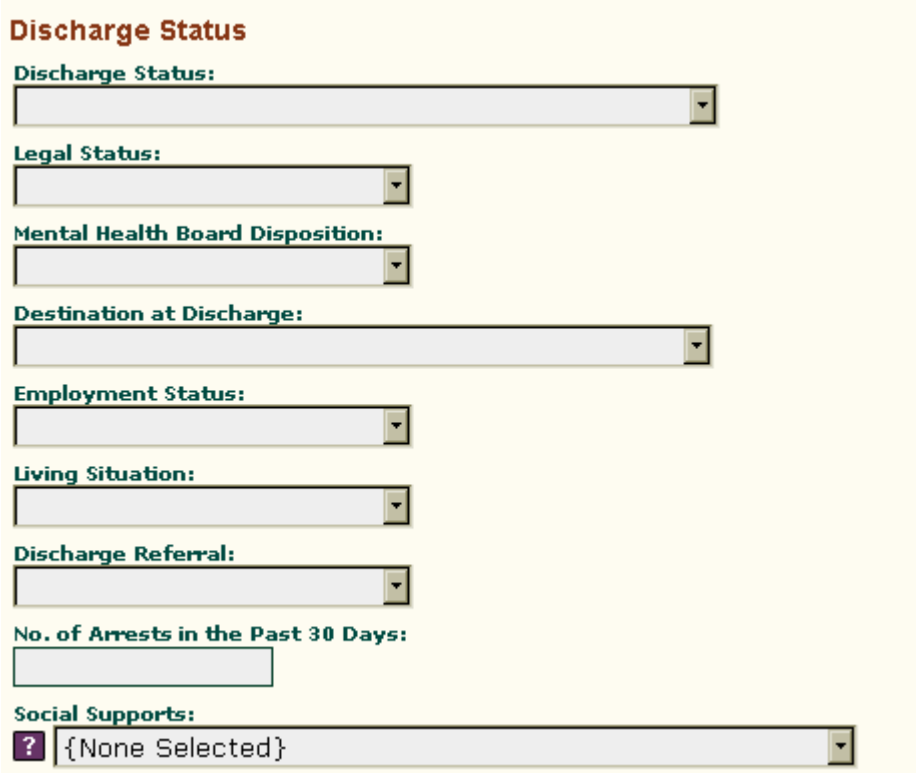
O **Discharge Referral** – Select from the drop down menu where the consumer was referred at Discharge.

Agricultural Action Center	Mental Health Commit Brd.	Private SA Provider
Alanon/Alateen/Etc.	Mental Health Court	Probation
Clergy	Mental Health Emergency	Prosecutor
Community Service Agency	Mental Health Non-Residential	Public Health Staff
Compulsive Gamb. Prov.	Mental Health Residential	Regional Center
Corrections	Mental Retardation Agency	SA Emergency/Detox.
County Extension Agent	Mid-Level Practitioner	SA Halfway House
Court Order	Nursing Facility	SA Methadone Detox.
Court Referral	Obsolete – SA Meth. Maint.	SA Outpatient Counseling
Defense Attorney	Obsolete – SA Partial Care	SA Prevention
Drug Court	Obsolete – Profess. Intervent.	SA Self-help Group
Employee Assist Prgm.	Obsolete – Profess. Supt.	SA Short-term Residential
Employers	Other Human Service Prov	SA Therapeutic Comm.
Family	Other Medical Facility	School Based Referral
Helpline	Parole	Self
Food Pantry	Police	Services Psychiatric Eval
Friend	Pre-trial Diversion	Soc Svc Sexual Perp Eval
Homeless/Shelter	Private Family Counselor	State Social Service
Hospital	Private Mental Hlth. Prac.	Tribal Elder or Official
Job Training Office	Private Physician	Veteran's Administration

O **Number of Arrests in the Past 30 Days** – Enter in the "text field" the number of arrests the consumer has had in the thirty days prior to Discharge. Enter (00) if none.

O **Social Supports** - Select from the drop down menu (see table below) the best description of the consumer's Social Supports at the time of Discharge. Refer to the Hover Text for a definition of Social Supports by placing the cursor over the (?) next to this field.

No attendance in the past month
1-3 times in the past month (less than once per week)
4-7 times in the past month (about once per week)
8-15 times in the past month (2 or 3 times per week)
16-30 times in the past month (4 or more times per week)
Some attendance in the past month, but frequency unknown)



Diagnosis

O **Date of Diagnosis** – Enter the consumer's most recent Date of Diagnosis in the format DD/MM/YYYY. You can also use the pop-up calendar to select the admission date.

O **Diagnosis Codes Axis I** – Select up to four Axis I codes from the drop down menu. The codes are presented in alphabetical order in the drop down menu. At least one Axis I code must be selected. If there is no is no Axis I diagnosis select "V71.09 No Diagnosis on Axis I or II" in the Axis I (A) field.

O **Diagnosis Codes Axis II** – Select up to four Axis II codes from the drop down menu. The codes are presented in alphabetical order in the drop down menu. At least one Axis II code must be selected. If there is no is no Axis II diagnosis select "V71.09 No Diagnosis on Axis I or II" in the Axis II (A) field.

O **Diagnosis Codes Axis III** – Enter up to four Axis III codes in the text fields. These fields are used to report any physical health issues the consumer reports having. At least one Axis III code must be entered. If there is no is no Axis III diagnosis enter "None Reported" in the Axis III (A) field.

- **Diagnosis Codes Axis IV** – Select as many Axis IV conditions from the multi-select boxes as apply. At least one Axis IV condition must be entered from the following choices:

  - Diagnosis Condition Deferred

  - Problems with access to health care services

  - Economic Problems

  - Problems with Primary Support Group

  - Educational Problems

  - Problems related to interaction with the legal system/crime

  - Housing Problems

  - Problems related to the social environment

  - Occupational Problems

  - Other Psychosocial and Environment Problems

- **Diagnosis Codes Axis V GAF** – This field is a text box for the user to enter a numeric value from 1 -100 to record the consumer's current Global Assessment of functioning (GAF) Score.

Date Of Diagnosis

31

Diagnosis Codes

Axis I:

Axis I (A):
{None Selected}

Axis I (B):
{None Selected}

Axis I (C):
{None Selected}

Axis I (D):
{None Selected}

Axis II:

Axis II (A):
{None Selected}

Axis II (B):
{None Selected}

Axis II (C):
{None Selected}

Axis II (D):
{None Selected}

Axis III:

Axis III (A):

Axis III (B):

Axis III (C):

Axis III (D):

Axis IV:

Axis IV:

- ☐ Diagnosis Condition Deferred
- ☐ Economic Problems
- ☐ Educational Problems
- ☐ Housing Problems
- ☐ Occupational Problems
- ☐ Problems with access to health care services
- ☐ Problems with Primary Support Group
- ☐ Problems related to interaction with the legal system/crime
- ☐ Problems related to the social environment
- ☐ Other Psychosocial and Environment Problems

Axis V GAF (Current):

Substances Used

For each of the Primary, Secondary, or Tertiary substances used, please complete the following information. If only a Primary Substance of use is reported you must select "Not Applicable" in the "Name" field of the Second and Third Substance in order to complete this section. If only a Primary and Secondary Substance of use is reported you must select "Not Applicable" in the "Name" field of the Third Substance in order to complete this section.

O **Name of Substance** - Select from the drop down menu the name of the substance used. These are presented alphabetically in the drop down.

O **Age of First Use** - Enter a two digit (00-99) number in the "text field" corresponding to the age when the consumer began using the substance.

O **Frequency** - Select from the drop down menu the choice that best describes the consumer's frequency of use. If "Other" is selected a "pop-up" box is presented for an up to 20 character text description.

1 – 2x's past week	Daily	Unknown
1 – 3x's past month	No use past month	
3 – 6x's past week	Other	

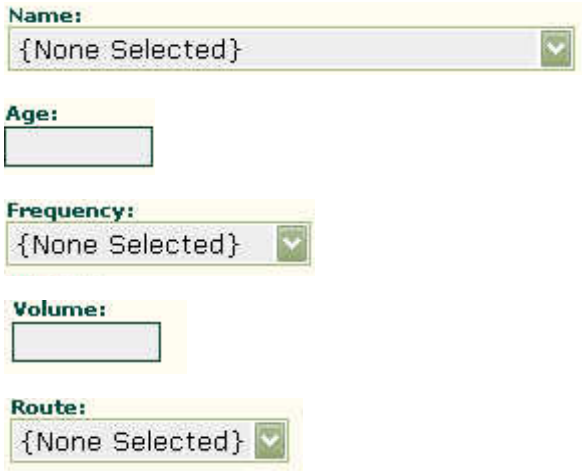
O **Volume** - Enter in the "text field" an up to (20) character description of the volume of the substance used.

O **Route** - Select from the drop down menu the choice that describes the route the consumer used to ingest the substance.

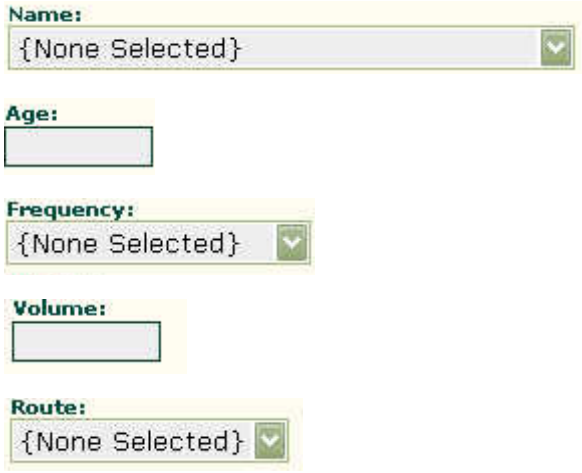
IV	Oral	Smoke
Nasal	Other	Unknown

Primary Substance/Second Substance/Third Substance (this set of fields appear for each of the three substances on the web screens).

Primary Substance



Second Substance



Third Substance

Saving Your Work

Be sure to click on the SAVE button at the bottom of the Discharge screen after you have entered the Substance Use information. This will complete the online Discharge process. If your submission was successful you will see the message below.

Submission Complete

Your request has been successfully saved.

Return to MyPractice Page

Appendix (I)

Appeals Process (NBHS)

Magellan Health Services reviews mental health and/or substance abuse services for the Department of Health and Human Services Division of Behavioral Health to determine if the service is medically necessary and appropriate for payment.

Once eligibility and provider enrollment has been confirmed and all pertinent information is gathered, the Care Manager compares the medical information to the appropriate clinical guidelines. If the clinical guidelines are met, and the care the client requires can only be provided in the requested setting, the Care Manger may authorize the Admission or Continued Stay Review. If the clinical guidelines are not met, or there is question regarding the level of care, the Care Manager will refer the case to Peer Review.

Psychiatrist Reviewer (PR) Requirements

Magellan Health Services ensures that a network of reviewers is accessible Monday through Friday 8:00 a.m. to 5:00 p.m. Psychiatrist reviewers (PR) will be practicing board certified or board eligible psychiatrists who are licensed in Nebraska and are located in a Nebraska-based office. Reviewers are trained and familiar with applicable program specifications.

Treatment Authorization or Denial

The Care Manger notifies the provider or the facility contact of the approval authorization decision within the same working day as the request for the review, and no later than the second working day following the request. Written notification including the authorization number is sent within 72 hours. If the service is not approved the peer review and reconsideration process will be followed.

Admission Review

Available pertinent medical information must be reviewed prior to or at the time of admission. This Admission Review is conducted to determine that the admission is medically necessary, that the services will be delivered in the most appropriate treatment setting.

When a facility fails to prior authorize services on the date of admission for an eligible member, an Admission Review is required on the date the provider calls. Days between the date of admission and the date of the call to the Care Manger will be technically denied and a Reconsideration Review will not be available through Magellan Health Services. Since prior authorization is a requirement, the facility will not be reimbursed for the care provided prior to the authorization and they cannot bill the client for technically denied days.

Continued Stay Review

A Continued Stay Review is a period review of available pertinent medical information conducted during the treatment episode. It is completed to ensure that the client continues to require and continues to receive treatment services in the most appropriate level of care.

It is the provider's responsibility to contact the Care Manager to complete the continued stay review prior to the last day of the existing authorization period to allow time for Peer Review before the authorization expires, if necessary.

Peer Review

When the Care Manager cannot determine that the clinical guidelines are met, or there is a question regarding the level or quality of care, the case will be referred for Peer Review. Peer review will be conducted for cases where a clinical determination to authorize cannot be made by the Care Manager, and the provider requests the Peer Review. During the initial step of the Peer Review, the Care Manager reviews the authorization request with the ASO psychiatrist within 24 hours of the authorization request. The ASO psychiatrist will determine if clinical guidelines are met and make an authorization determination, including alternative treatment recommendations. The Care Manager will notify the provider of the determination of the initial authorization request and explain the availability to discuss the Peer Review determination with the ASO Psychiatrist. The provider may take up to four hours to confirm with Magellan the request for a peer-to-peer discussion. The peer-to-peer discussion must be a discussion between the Practitioner or designee and the Psychiatrist Reviewer. The Appeals Coordinator will arrange the peer to peer discussion within one business day of the request for the peer-to-peer discussion.

The peer-to-peer discussion must be timely and the provider must have a back-up procedure for situations where the original provider is not available. The designee must be available within one business day. If the provider declines to complete a peer-to-peer discussion or fails to request or schedule the peer-to-peer discussion, the Psychiatrist Reviewer's initial determination is upheld.

The PR will notify the practitioner of the Peer Review decision at the time of the peer-to-peer discussion. Written notification including medical rational for that decision and the authorization or denial number will be sent to the supervising practitioner, and the provider within 24 hours of the decision.

Magellan Health Services has 72 hours following the authorization request to complete the entire Peer Review process, including written notification. The PR, using his/her medical judgment, will determine the appropriateness of the admission or continued stay review and provide specific medical rational for the decision.

If the PR denies the care at Peer Review, the provider's next step is a Reconsideration Review. If a client is discharged pending a Peer or Reconsideration Review, the case becomes a Retrospective Review. The provider does not need to complete a peer-to-peer discussion in order to be eligible for Reconsideration.

Reconsideration Review

If a PR issues a denial at Peer Review, a Reconsideration Review of that decision is available. A client, supervising practitioner or provider may have up to 90 days of the notification results of the Peer Review to request a Reconsideration Review. The provider can determine the level or urgency of the Reconsideration. If the provider determines that the reconsideration is urgent (i.e., the member is in a 24 hour facility) the reconsideration determination is made within 72 hours of the request for reconsideration. If the provider determines that the level of urgency for the reconsideration is standard (i.e., a request for psychological testing), the determination is made within 14 days of the request for reconsideration. If the provider does not indicate level of urgency, the ASO will process all acute requests within 72 hours and

all other requests as a standard reconsideration request and issue a determination with 14 days of the request for reconsideration. A PR will complete the Reconsideration Review within 30 calendar days of receipt of the request. The Appeals Coordinator will select a PR not involved in the Peer Review decision to conduct the Reconsideration Review. The client's medical information supplied by the provider will be available to the PR who will independently make a decision regarding medical necessity.

Reconsideration Reviews will be completed in writing.

Reconsideration Review PRs can uphold, reverse, or modify the Peer Review denial decision. Written notification including medical rational of that decision and the authorization or denial number will be sent to the provider and/or member within 24 hours of that decision. A Reconsideration Review must be completed prior to the provider or member requesting a Sate Fair Hearing. The Reconsideration Review process is not available for quality issues and technical denials.

Retrospective Review

If the client discharges pending a Peer Review or Reconsideration Review, the case becomes a Retrospective Review. Retrospective Reviews must be requested in writing and accompanied by the complete medical record within 60 calendar days.

Technical Denial

A technical denial will be issued for admissions that are not authorized prior to or at the time of admission. The day(s) from admission to the date Magellan is contacted are technically denied. Technical denials will be issued for admissions occurring after normal business hours that are not reviewed during the following business day, continued stay reviews that are not done timely, and if the retrospective review is requested more than 60 calendar days. A Reconsideration Review for a technical denial is not available through Magellan Health Services.

Reinstatement

Following a denial, if the client is not discharged and again meets clinical guidelines, the Care Manger will reinstate the authorization from the date the client again met clinical guidelines. It is the responsibility of the facility or supervising practitioner to request a Reinstatement Review.

Appeals

If a denial is upheld or adversely modified at the Reconsideration Review process, the facility or client/guardian may appeal the Reconsideration Review decision in writing to DHHS within 90 calendar days from the date of the Reconsideration Review denial letter.

The mailing address for DHHS Division of Behavioral Health Administrative Appeal requests is:

DHHS – Division of Behavioral Health
ATTN: Fair Hearing Officer
301 Centennial Mall South
PO Box 95026
Lincoln, NE 68509-5026
(402) 471-7856

Appeals Process (Medicaid)

Magellan Health Services reviews mental health and/or substance abuse services for the Nebraska Medicaid Managed Care Program and for certain levels of care for the Nebraska Medical Assistance Program to determine if the service is medically necessary and appropriate for payment.

Reviewing Treatment

Once Medicaid eligibility and provider enrollment has been confirmed and all pertinent information is gathered, the Care Manager compares the medical information to the appropriate clinical guidelines. If the clinical guidelines are met, and the care the client requires can only be provided in the requested setting, the Care Manger may authorize the Admission or Continued Stay Review. If the clinical guidelines are not met, or there is question regarding the level of care, the Care Manager will refer the case to Peer Review.

Department approved clinical guidelines:

1. Acute inpatient hospital clinical guidelines from Title 471 NAC 20-007.05 for clients 21 years of age and older;
2. Acute inpatient hospital admission clinical guidelines from Title 471 32-008.05 for clients 20 years of age and younger; and
3. Department-approved clinical guidelines for residential, treatment group home, treatment foster care home, day treatment and outpatient services:

www.magellanprovider.com/forms/handbooks/supplements/ne_medicaid/neb_index.asp

Psychiatrist Reviewer (PR) Requirements

Magellan Health Services ensures that a network of reviewers is accessible Monday through Friday 8:00 a.m. to 5:00 p.m. Psychiatrist reviewers (PR) will be practicing board certified psychiatrists who are licensed in Nebraska and are located in a Nebraska-based office. Reviewers are trained and familiar with applicable Medicaid program specifications.

Treatment Authorization or Denial

The Care Manger notifies the provider or the facility contact of the approval authorization decision within the same working day as the request for the review, and no later than the second working day following the request. Written notification including the authorization number is sent within 72 hours. If the service is not approved the peer review and reconsideration process will be followed.

Admission Review

Available pertinent medical information must be reviewed prior to or at the time of admission to an acute inpatient psychiatric hospital or psychiatric unit, residential treatment center, treatment group home, treatment foster care or day treatment program. This Admission Review is conducted to determine that the admission is medically necessary, that the services will be delivered in the most appropriate treatment setting, and that the services meet professionally recognized standards of care for Medicaid payment purposes.

When a facility fails to prior authorize services on the date of admission for a Medicaid eligible member, an Admission Review is required on the date the provider calls. Days between the date of admission and the date of the call to the Care Manger will be technically denied and a Reconsideration Review will not be available through Magellan Health Services. Since prior authorization is a requirement, the facility and supervising practitioner will not be reimbursed for the care provided prior to the authorization and they cannot bill the client for technically denied days.

Continued Stay Review

A Continued Stay Review is a period review of available pertinent medical information conducted during the treatment episode. It is completed to ensure that the client continues to require and continues to receive services in the most appropriate treatment setting, and the services provided meet professionally recognized standards of care for Medicaid payment purposes.

It is the provider's responsibility to contact the Care Manager to complete the continued stay review prior to the last day of the existing authorization period to allow time for Peer Review before the authorization expires, if necessary.

Peer Review

When the Care Manager cannot determine that the clinical guidelines are met, or there is a question regarding the level or quality of care, the case will be referred for Peer Review. Peer clinical review will be conducted for cases where a clinical determination to authorize cannot be made by the Care Manager, and the provider requests the Peer Review. During the initial step of the Peer Review, the Care Manager reviews the authorization request with the ASO psychiatrist within 24 hours of the authorization request. The ASO psychiatrist will determine if clinical guidelines are met and make an authorization determination, including alternative treatment recommendations. The Care Manager will notify the provider of the determination of the initial authorization request and explain the availability to discuss the Peer Review determination with the ASO Psychiatrist. The provider may take up to four hours to confirm with Magellan the request for a peer-to-peer discussion. The peer-to-peer discussion must be a discussion between the Practitioner or designee and the Psychiatrist Reviewer. The Appeals Coordinator will arrange the peer to peer discussion within one business day of the request for the peer-to-peer discussion.

The peer-to-peer discussion must be timely and the provider must have a back-up procedure for situations where the original provider is not available. The designee must be available within one business day. If the provider declines to complete a peer-to-peer discussion or fails to request or schedule the peer-to-peer discussion, the Psychiatrist Reviewer's initial determination is upheld.

The PR will notify the practitioner of the Peer Review decision at the time of the peer-to-peer discussion. Written notification including medical rational for that decision and the authorization or denial number will be sent to the supervising practitioner, and the provider within 24 hours of the decision.

Magellan Health Services has 72 hours following the authorization request to complete the entire Peer Review process, including written notification. The PR, using his/her medical judgment, will determine the appropriateness of the admission or continued stay review and provide specific medical rational for the decision.

If the PR denies the care at Peer Review, the provider's next step is a Reconsideration Review. If a client is discharged pending a Peer or Reconsideration Review, the case becomes a Retrospective Review. The provider does not need to complete a peer-to-peer discussion in order to be eligible for Reconsideration.

Reconsideration Review

If a PR issues a denial at Peer Review, a Reconsideration Review of that decision is available. A client, supervising practitioner or provider may have up to 90 days of the notification results of the Peer Review to request a Reconsideration Review. The provider can determine the level or urgency of the Reconsideration. If the provider determines that the reconsideration is urgent (i.e., the member is in a 24 hour facility) the reconsideration determination is made within 72 hours of the request for reconsideration. If the provider determines that the level of urgency for the reconsideration is standard (i.e., a request for psychological testing), the determination is made within 14 days of the request for reconsideration. If the provider does not indicate level of urgency, the ASO will process all acute requests within 72 hours and all other requests as a standard reconsideration request and issue a determination with 14 days of the request for reconsideration. A PR will complete the Reconsideration Review within 30 calendar days of receipt of the request.

The Appeals Coordinator will select a PR not involved in the Peer Review decision to conduct the Reconsideration Review. The client's medical information supplied by the provider and/or supervising practitioner will be provided to the PR who will independently make a decision regarding medical necessity.

Reconsideration Reviews will be completed in writing.

Reconsideration Review PRs can uphold, reverse, or modify the Peer Review denial decision. Written notification including medical rational of that decision and the authorization or denial number will be sent to the supervising practitioner, provide and/or member within 24 hours of that decision. A Reconsideration Review must be completed prior to the provider or member requesting a Sate Fair Hearing. The Reconsideration Review process is not available for quality issues and technical denials.

Retrospective Review

If the client discharges pending a Peer Review or Reconsideration Review, the case becomes a Retrospective Review.

Retrospective Reviews must be requested in writing and accompanied by the complete medical record within 60 calendar days of the client being determined Medicaid eligible. A technical denial will be issued if the review is requested more than 60 calendar days after Medicaid eligibility is determined. Reconsideration Reviews for technical denials is not available through Magellan Health Services. If a client becomes Medicaid eligible during an acute inpatient hospital or Day Treatment stay, the review can be done telephonically.

Technical Denial

A technical denial will be issued for admissions that are not authorized prior to or at the time of admission. The day(s) from admission to the date Magellan is contacted are not authorized prior to or at the time of admission. The day(s) from admission to the date Magellan is contacted are technically denied. Technical denials will be issued for

admissions occurring after normal business hours that are not reviewed during the following business day, continued stay reviews that are not done timely, and if the retrospective review is requested more than 60 calendar days after Medicaid eligibility is determined. A Reconsideration Review for a technical denial is not available through Magellan Health Services.

Reinstatement

Following a denial, if the client is not discharged and again meets clinical guidelines, the Care Manger will reinstate the authorization from the date the client again met clinical guidelines. It is the responsibility of the facility or supervising practitioner to request a Reinstatement Review.

Appeals

If a denial is upheld or adversely modified at the Reconsideration Review process, the supervising practitioner, facility or client may appeal the Reconsideration Review decision in writing to DHHS within 90 calendar days from the date of the Reconsideration Review denial letter.

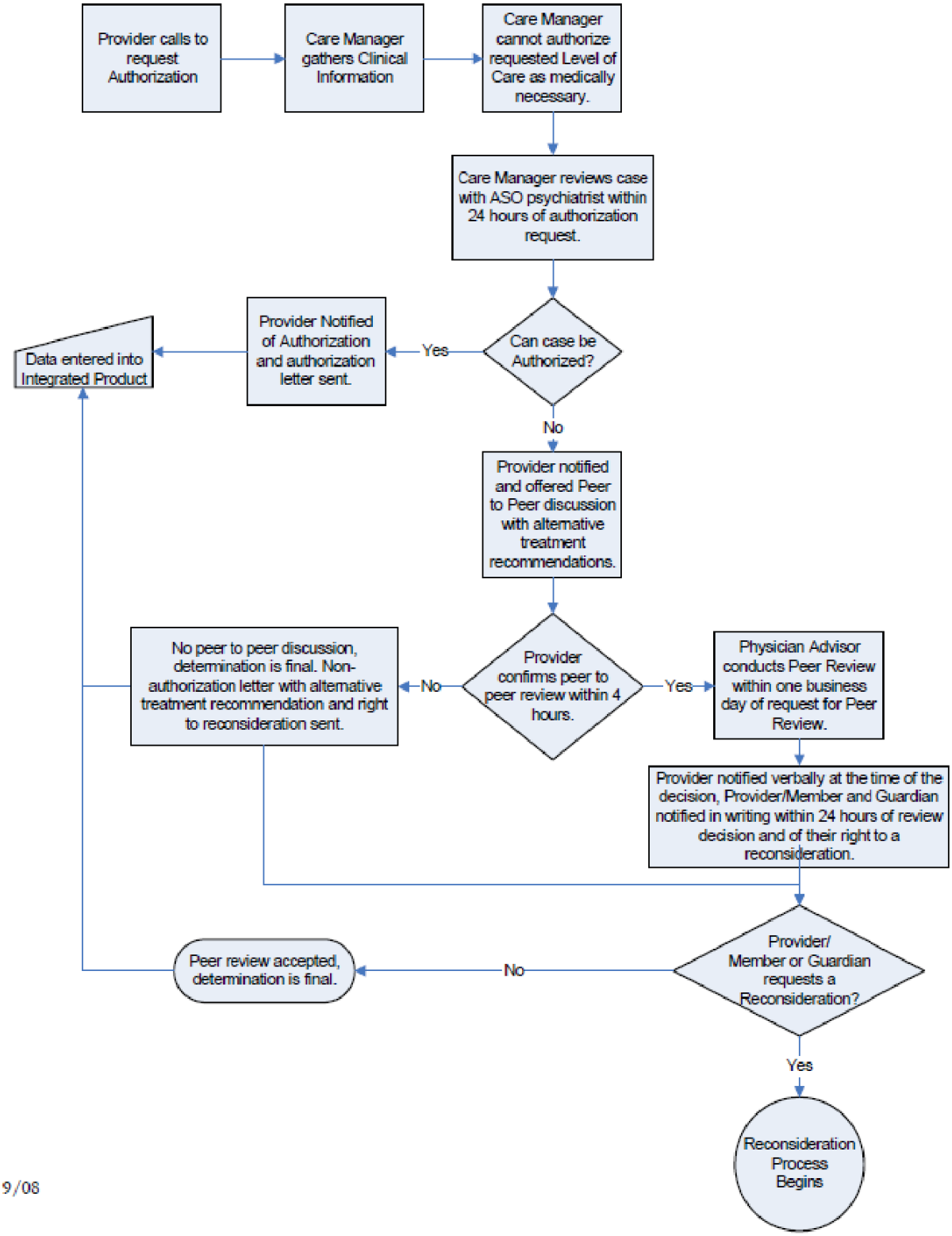
The mailing address for HHS Administrative Appeal requests is:
Legal Services - Hearing Section
PO Box 98914
Lincoln, NE 68509-8914

DHHS will notify Magellan Health Services when a Review Activity Summary is needed for a State Fair Hearing. A Magellan QI Reviewer will summarize review activity for that case from its review file. Magellan Health Services will send the Review Activity Summary, the Peer Review denial letter, the Reconsideration Review denial or adversely modified letter to DHHS within 14 days following the request.
technically denied.

MAGELLAN HEALTH SERVICES
Getting Better All the Time

Nebraska
Division of Medicaid and Long Term Care
and the
Division of Behavioral Health

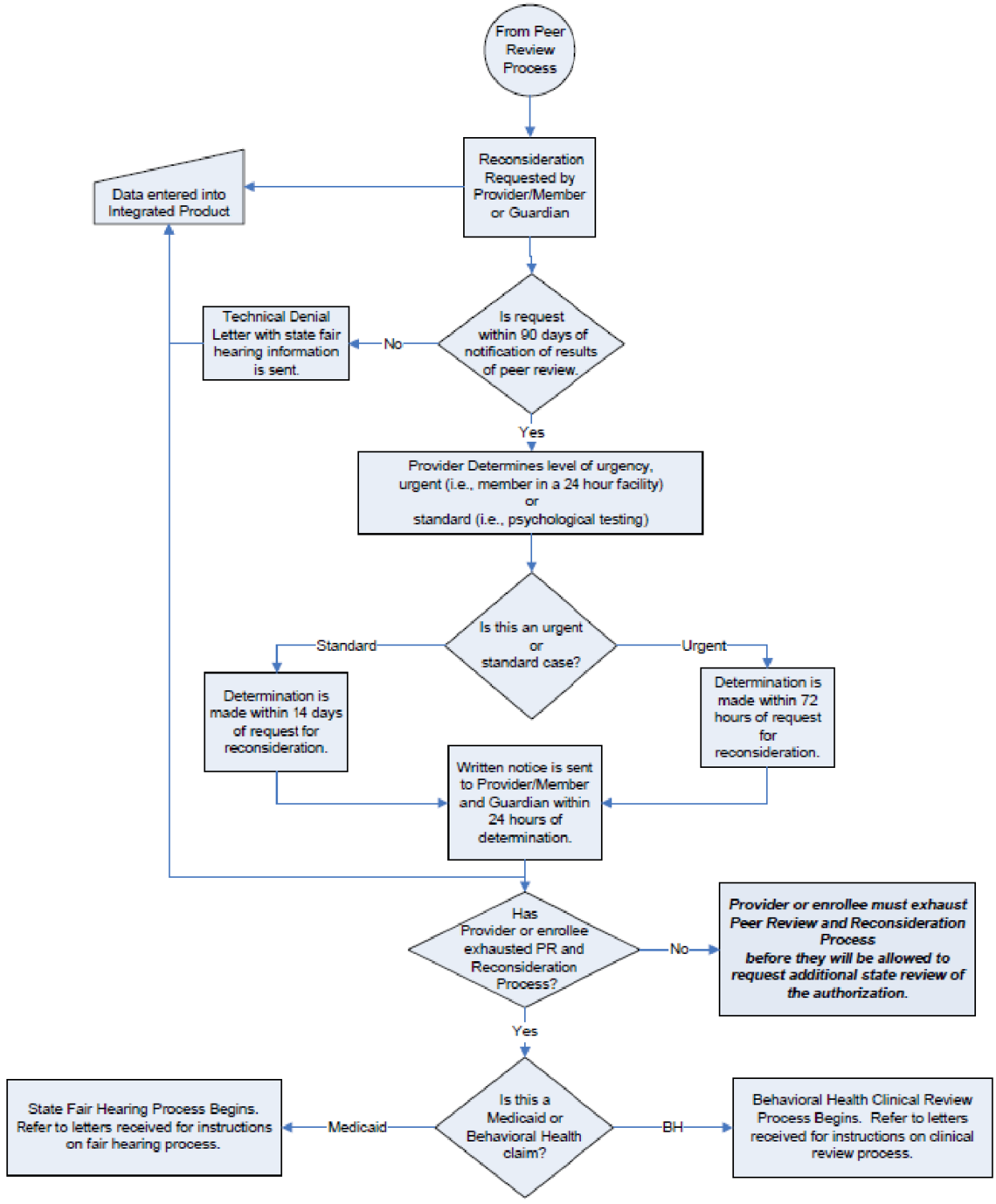
Peer Review Process



9/08

MAGELLAN HEALTH SERVICES
Getting Better All the Time

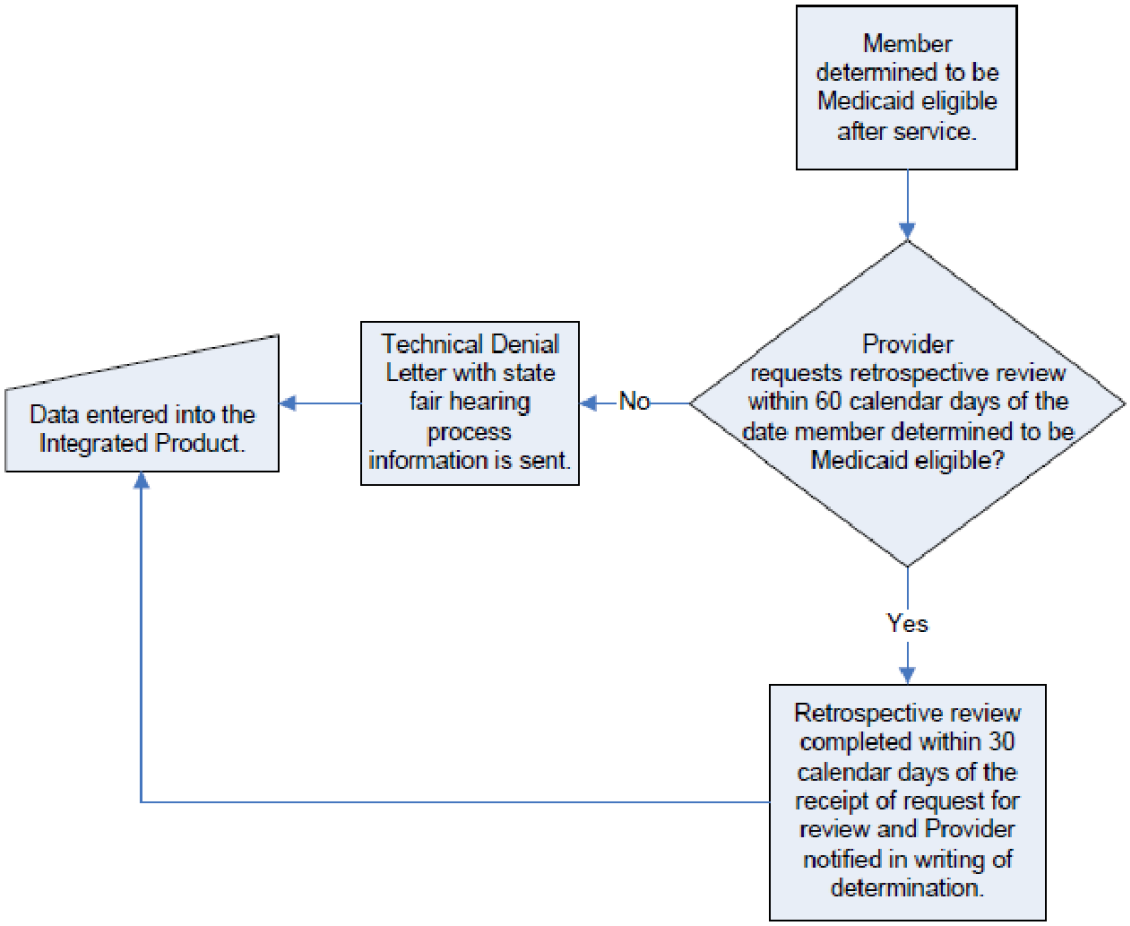
Nebraska
Division of Medicaid and Long Term Care
and the
Division of Behavioral Health
Reconsideration Process



9/08

Nebraska
Division of Medicaid and Long Term Care
and the
Division of Behavioral Health

Retrospective Review Process



9/08

Appendix (II)

Reports

This appendix provides a list of available BHS reports and describes the content of each report, the report parameters, and requirements for inclusion of the data in each report.

Data Source(s) - Data for all reports will be compiled through the Magellan Integrated Product system using data collected from the Nebraska-specific magellanprovider.com web pages, and will be reported on DWPRD1 using ODS tables via Nebraska auxiliary file IPP256.

MCOO002A Emergency Protective Custody Demographics Report

1. Report Description - This report is for the Nebraska Behavioral Health System. It is a rolling month, fiscal year to date summary of demographic information about members who were taken into Emergency Protective Custody. The counts of members are listed by various demographic categories such as gender, race, age, county of admission, employment status at admission, reason for admission etc. The report is broken down by region and a separate section is included to show the counts for all regions combined.

2. Selection Criteria - The report produces Demographic counts for NBHS members who have been admitted for Emergency Protective Custody during the reporting period as indicated by Magellan Outcome code '225' (EPC Services) and Reason for EPC Admission is one of the following:

   001 - Dangerous to self/neglect
   002 - Dangerous to self/suicide attempt
   003 - Dangerous to others
   004 - Both dangerous to self and others

3. Content - The report shows counts of members in each of the following demographic categories:

   Number of Admissions
   Number of Different Persons Served
   Number of Discharges
   Gender
   Race
   Age
   County of Admission
   Employment Status at Admission
   Insurance Coverage/Pay source
   Legal Status at Admission
   Reason for EPC Admission
   Community Services
   Reason for Admission
   Diagnostic Categories
   Length of Stay – total and average

MCWOO003A Authorized IPPC Days

1. Report Description - The purpose of the report is to provide Nebraska Behavioral Health System (NBHS) personnel with a report of authorized in-patient post-commitment (IPPC) days by provider. When consumers are admitted to crisis centers for Emergency Protective Custody (EPC) and are then committed to a regional center or short-term residential facility by the Mental Health Board (MHB) but have to wait for a bed to be available at the facility, the patients stay at the crisis centers – these are post-commitment days. This report counts all days where post-commitment treatment at the crisis center was required and was authorized. The report will display data for the requested period, generally the fiscal year to date, based on the dates of admission to IPPC during the reporting period.

2. Selection Criteria - This report counts only those who were authorized for in-patient post-commitment service. Criteria for selection: 1) the consumer had been admitted for EPC services, determined by outcome code '225' in the admission record and legal status '009' (EPC) or '016' (CPC) in the auxiliary (IPP256) record; 2) had an MHB hearing and been committed to a facility, determined by the presence of a commitment date in the auxiliary record; 3) had been authorized for post-commitment care, reflected in the patient's next admission record having outcome code '111'; and 4) was admitted to the identified level of care per commitment. Selection of records is based on authorization to IPPC at a selected facility during the reporting period. Patient must have been committed by the MHB prior to the IPPC authorization; subsequent admittance to a regional center or to short-term residential treatment is also required.

3. Content – This report displays the number of authorized IPPC days by Region by facility for each month in the fiscal year the report is generated. Totals for each facility and for each Region in aggregate by month are also reported.

MCOO00116A Annual Re-Registration Report

1. Report Description - The purpose of the report is to show by provider by service by consumer the registered services within the NBHS Reporting Group that need to be re-registered. The report is updated monthly to reflect new registrations that will lapse during the reporting period. These entries will remain on the report until a Provider enters the re-registration or discharges the registration in the event the consumer is no longer receiving those services.

2. Selection Criteria - Record selection for inclusion in this report is based on:

   Consumers belonging to the NBHS Reporting Group.

   Consumers that are registered for services on /prior to the user defined report end date and have a registration End Date that falls on/prior the user defined report end date.

   Do not have a discharge date or a later re-registration.

3. Content - This report shows Region, Service Type, Provider ID, Provider Name, Patient Name, Patient SSN, Case #, Episode #, Encounter # and the Re-Registration Due Date. Registrations on the report are grouped by Region and Service Type.

MCWO0019A Crisis Center Destination at Discharge Report

1. Report Description - This report is used to track the services consumers are accessing upon discharge from the Crisis Center Facilities.
   This report provides subsequent service information for each consumer discharged from a crisis center with a discharge date that falls between the Start Date and End Date inputs in the Parameter Input Screen

2. Selection Criteria - This report will list only those discharges associated with consumers having an admission status of Emergency Protective Custody (as determined by outcome code '225' in the admission record) and a discharge date that falls between the Start Date and End Date of the reporting period. In order to ensure that the admission to the treatment facility is the one ordered by the commitment in the crisis center, the following conditions must apply in addition to the fact that there is a commitment date:

   The subsequent admission to a treatment center must correspond to the treatment type listed as the destination at discharge.

   The Commit Date assigned must fall within the Admit Date and Discharge Date of the crisis center registration.

   The Outcome Type may not be 111.

3. Content - This report provides the Magellan consumer case number, EPC admission date, MHB commitment date (if applicable), EPC discharge date, next admission date, wait days, provider and destination at discharge per EPC discharge data are listed for each consumer. The report is organized by region, by provider. A summary by Region provides a total count of consumers discharged to each of the possible destinations. Please note that "Wait Days" will only be calculated when there is a commitment date.

MCWO0020A Count of Emergency Protective Custody Admits By Provider

1. Report Description - This report is used to track the number of consumers per month who are admitted to Emergency Protective Custody services (as determined by outcome code '225' in the admission record) at admission to an EPC facility for a specified time period. The report provides a duplicated count of the number of EPC admissions by provider by month.

2. Selection Criteria - The report produces duplicated counts (will re-count those who were admitted more than once) of consumers who have been admitted for Emergency Protective Custody during the reporting period as indicated by Magellan Outcome code '225' (EPC Services) and Reason for EPC Admission is one of the following:

    001 - Dangerous to self/neglect
    002 - Dangerous to self/suicide attempt
    003 - Dangerous to others
    004 - Both dangerous to self and others

    The Admission Date must be equal to or greater than the Start Date and equal to or less than the End Date of the reporting period.

3. Content – The total number of admissions for the reporting period (including re-admissions) is presented by provider name and displayed in ascending alpha order. A total for all providers for the reporting period is also displayed.

MCWO0020A NBHS Commitment Volume Report

1. Report Description – This report is used to track the number of consumers that are admitted to Emergency Protective Custody facilities who are subsequently committed by the Mental Health Board (MHB) to in-patient care. This report displays the number of commitments in each month of the reporting period for each EPC facility.

2. Selection Criteria – In order to be included in this report the consumer:

   a) must have been admitted for Emergency Protective Custody services as determined by outcome code '225' in the admission record,

   b) was admitted to a designated EPC facility,

   c) had an MHB hearing and had been committed to an inpatient facility, determined by the presence of a commitment date in the auxiliary (IPP256) record, and

   d) the commitment date must be after the admit date for the crisis center. Records are sorted by the region of admission, crisis center name, and county of admission.

3. Content – This report displays the number of commitments by Region by provider by month during the fiscal year being reported. It includes the commitment totals by County of Residence and provides a total number of commitments by Region by month.

MCWO0024A Admission Summary

1. Report Description - The purpose of this report is to provide Nebraska Behavioral Health System (NBHS) Regions and their providers with a report of the number of admissions to their programs for the reporting period and fiscal YTD and of consumers still active at the report end date, and some demographics of those consumers. Providers will see only their own admissions. Regions will see admissions only for records associated with their providers, based on the region of admission in each record.

2. Selection Criteria - Selection of data is based on admissions to NBHS services during report period and appropriate fiscal year. For provider reports, records will additionally be restricted to only those where the requestor was the provider. For Region reports, records will additionally be restricted to only those where provider's sub-network falls under the region requesting the report. For Re-registrations, new admits are determined by the earliest admit date occurring during the report period. For all other services, new admits are determined by the authorization start date or admit date (if no authorization) occurring during the report period. YTD Admissions count admissions from July 1 of the fiscal year of the requested period through the report end period. Current Consumers are those admitted prior to the report end date and not discharged before the report end date. For reports where a specific region was selected (not allowed for Regions), only records where the provider's sub-network is associated with that region will be selected.

3. Content – This report displays number of new admissions during the reporting period, the number of YTD admissions and the number of current consumers by service type by provider. In addition it displays the following demographic information for each:

    Gender
    Age at Admission
    Income
    Race
    Diagnosis
    Insurance Type
    County of Admission
    Reason for Admission

MCWO0026A Discharge Summary

1. Report Description - The purpose of the report is to provide Nebraska Behavioral Health System (NBHS) providers with a report of the number of discharges for the reporting period and fiscal YTD and of consumers still active at the report end date, and some demographics of those consumers. Requestors will have the ability to request the report grouped by region, provider, and service type or as a summary report for the report period of their choosing. Providers will be able to access a summary of their own data only, regions will be able to access data only for their region.

2. Selection Criteria - Selection of data is based on discharges from NBHS services during report period and appropriate fiscal year. For provider reports, records will additionally be restricted to only those where the requestor was the provider. For Region reports, records will additionally be restricted to only those where provider's sub-network falls under the region requesting the report. For Re-registrations, new discharges are determined by the latest discharge date occurring during the report period. For all other services, new discharges are determined by the discharge date occurring during the report period. YTD Discharges count discharges from July 1 of the fiscal year of the requested period through the report end period. Current Consumers are those admitted prior to the report end date and not discharged before the report end date. For reports where a specific region was selected (not allowed for Regions), only records where the provider's sub-network is associated with that region will be selected.

3. Content - This report displays number of new admissions during the reporting period, the number of YTD admissions and the number of current consumers by service type by provider. In addition it displays the following demographic information for each:

    Gender
    Age at Admission
    Income
    Race
    Diagnosis
    Insurance Type
    County of Admission
    Reason for Admission

MCWO0033A Utilization Summary

1. Report Description – This report provides Nebraska Behavioral Health System (NBHS) personnel and the Nebraska providers with a report of the number of consumers served, and the number of units actually used for various services provided during the reporting period. The data is grouped by region, provider and service type. Providers will have access to their own data only, regions will see data only for their region, based on the region of admission in each record.

2. Selection Criteria - Selection of data is based on consumers authorized to or registered for services during the report period. For provider requests via the web, records will additionally be restricted to only those where the requestor was the provider. For region requests, records will additionally be restricted to only those where the region of admission is the same as the region requesting the report. For reports where a specific region was selected, only records where that region is the region of admission will be selected.

3. Content – This report displays the provider name, the service provided, whether it was a registered service, the number of consumers served, and the actual number of units of service provided during the reporting period for each service. The data is grouped by region (for Region users), provider and service type. Users will have the ability to select the report begin date and the report end date for the period they wish to see.

MCWO0036A Discharge Compliance Report

1. Report Description - This report is designed to display lapsed authorizations and registrations which will allow providers to identify those authorizations and registrations that need to be discharged or re-authorized.

2. Selection Criteria – This report will include all authorizations that have lapsed by a week or more and no discharge date has been entered. It will also include all registrations that have had no encounter data entered within the previous 90 days. The exception for registered services is Medication Management registrations that have no encounter data entered within the previous 180 days.

3. Content – Provider versions of this report will include the Provider Name, Consumer Name, Consumer SSN, Service Type, Authorized or Registered Service, Case, Episode, and Encounter Number, Authorization Start Date, Authorization End Date, and Lapsed or Inactive authorization or registration type. The Region version of the report will include a summary by provider that includes the number of lapsed authorizations and registrations and the number of inactive registrations. A total of each category by Region is also provided.

Appendix (III)

Living Situation Definitions

Private Residence WITHOUT support – Individual lives in a house, apartment, trailer, hotel, dorm, barrack, and/or Single Room Occupancy.

Private Residence RECEIVING Housing Related Assistance
Support – (consistent with definition of Supported Housing – URSTable 16) – Individual has been found eligible and is receiving ongoing monthly benefits under the Nebraska Housing Related Assistance program. Exclude consumers who received a one time payment and are now in a private residence without supports. These consumers should be reported under "Private Residence WITHOUT support".

Private Residence RECEIVING other support – (consistent with definition of Supported Housing)

- Individual lives in a house, apartment, trailer, hotel, dorm, barrack, and/or Single Room Occupancy (SRO) **and**
- Receives planned support from to maintain independence in his/her private residence. This may include individualized services to promote recovery, manage crises, perform activities of daily living, and/or manage symptoms. Support services are delivered in the person's home environment. The person providing the support services may include a family member or a friend living with the consumer or a person/organization periodically visiting the home.

Foster Home – Licensed Foster Home or Therapeutic Foster Care

Regional Center – Lincoln Regional Center, Norfolk Regional Center [designated as Institutes of Mental Disease (IMD)].

Residential Treatment – Individual resides in a residential care facility with care provided on a 24 hour, 7 day a week basis and funded through Mental Health or Substance Abuse funds by the Division of Behavioral Health such as Psychiatric Rehabilitation, Short Term Residential, Partial Hospitalization, Therapeutic Community, Intermediate Residential, Halfway House, etc.

Other Institutional Setting - Individual resides in a licensed institutional care facility with care provided on a 24 hour, 7 day a week basis. This level of care may include a Mental Health Centers, Substance Abuse Treatment Centers, Skilled Nursing/Intermediate Care Facility, Hospitals, Assisted Living, DD centers, or Veterans Affairs Hospital, etc.

Crisis Residence - A residential (24 hours/day) stabilization program that delivers services for acute symptom reduction and restores consumers to a pre-crisis level of functioning. These programs are time limited for persons until they achieve stabilization. Crisis residences serve persons experiencing rapid or sudden deterioration of social and personal conditions such that they are clinically at risk of hospitalization but may be treated in this alternative setting.

Children's Residential Treatment Facility - Children and Youth Residential Treatment Facilities (RTF's) provide fully-integrated mental health treatment services to seriously emotionally disturbed children and youth. An organization, not licensed as a psychiatric hospital, whose primary purpose is the provision of individually planned programs of mental health treatment services in conjunction with residential care for children and youth. The services are provided in facilities which are certified by state or federal agencies or through a

national accrediting agency.

Jail/ Correctional Facility - Individual resides in a Jail and/or Correctional facility with care provided on a 24 hour, 7 day a week basis. This level of care may include a Jail, Correctional Facility, Prison, Youth Authority Facility, Juvenile Hall, Boot Camp, or Boys Ranch.

Homeless/ Shelter - A person has no permanent place of residence where a lease or mortgage agreement between the individual and the owner exists.

- A person is considered homeless if he/she lacks a fixed, regular, and adequate nighttime residence and/or his/her primary nighttime residency is:
- A supervised publicly or privately operated shelter designed to provide temporary living accommodations,
- An institution that provides a temporary residence for individuals intended to be institutionalized, or
- A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (e.g., on the street).

Child Living with Parent/Relative - youth under the age 0-17, or transitioning youth 18-21 living with Parent, other relatives, etc.

Youth Living Independently - youth under the age 0-17, or transitioning youth 18-21 with individual's own identifiable residence with responsible for that place.

Other - Living Situations not covered above.

Dependent Living: refers to living in a supervised setting such as a residential institution, halfway house or group home, and children (under age 18) living with parents, relatives or guardians or in foster Care.

Independent Living: refers to living alone or with others without supervision.

Supported Housing: Services to assist individuals in finding and maintaining appropriate housing arrangements. This activity is premised upon the idea that certain consumers are able to live independently in the community only if they have support staff for monitoring and/or assisting with residential responsibilities. These staff assist consumers to select, obtain, and maintain safe, decent, affordable housing and maintain a link to other essential services provided within the community. The objective of supported housing is to help obtain and maintain an independent living situation. Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities, criteria identified for supported housing programs include: housing choice, functional separation of housing from service provision, affordability,

NOTE: if "Living Situation" at Admission is UNKNOWN, the default reporting is "Unknown".

Appendix (IV)

Nebraska SPMI Criteria

For Adults with Mental Illness – Meets Nebraska SPMI Criteria: Select 'Yes' or 'No' based on provider's assessment using the criteria listed below:

a. The individual is age 18 and over,

b. Has a primary diagnosis of schizophrenia, major affective disorders, or other major mental illness under the current edition of the Diagnostic and Statistical manual of Mental Disorders published by the American Psychiatric Association. Developmental Disorders, or Psychoactive Substance Use Disorders may be included if they co-occur with the primary mental illnesses listed above;

c. Are at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed mental health services are not provided, and this pattern has existed for twelve (12) months or longer or is likely to endure for twelve (12) months or longer, and

d. Degree of limitation that seriously interferes with the individual's ability to function independently in an appropriate and effective manner, as demonstrated by functional impairments which substantially interferes with or limits two of three areas:

    1. Vocational/Educational
    2. Social Skills
    3. Activities of Daily Living

NOTE: For item 'b', diagnosis #295 – 298.9 (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) c 2000 American Psychiatric Association. Schizophrenia (295), Mood Disorders including Bipolar and major Depression (296), Delusional Disorder (297.1), Shared Psychotic Disorder (297.3), Brief Psychotic Disorder (298.8), and Psychotic Disorder NOS (298.9) ["Not Otherwise Specified"].

Nebraska SED Criteria

Meets Nebraska SED Criteria: Select 'Yes' or 'No' based on provider's assessment, using the criteria listed below:

a. The youth's age must range from birth up to age 18, however, for purpose of transition into adult services, the youth may be age 18 to 20,
b. The youth must have a mental illness diagnosable under the current edition of the Diagnostic and Statistical manual of Mental Disorders published by the American Psychiatric Association,

c. The condition must be persistent in that it has existed for one year or longer, or is likely to endure for one year or longer and

d. The mental illness must result in functional impairments in two (2) or more of the following areas:

    1. Self-care at an appropriate developmental level,
    2. Developmentally appropriate perception and expressive language
    3. Learning,

4. Self-direction, including developmentally appropriate behavioral controls, decision-making judgment, and value systems and
5. Capacity for living in a family or family equivalent

Appendix (V)

DSM IV Codes

29602 --- Bipolar I single/manic/moderat
29600 --- Bipolar I single/manic/unspec
29689 --- Bipolar II disorder
V6289 --- BIQ/spiritual/phase of life
30183 --- Borderline personality disordr
29880 --- Brief psychotic disorder
30751 --- Bulimia nervosa
30520 --- Cannabis abuse
30430 --- Cannabis dependence
V7102 --- Child/adolesc antisocial behvr
29910 --- Childhood disintegrative dsrdr
30722 --- Chronic motor/vocal tic disrdr
30745 --- Circadian rhythm sleep disordr
30560 --- Cocaine abuse
30420 --- Cocaine dependence
29490 --- Cognitive disorder NOS
30790 --- Communication disorder NOS
31280 --- Conduct disorder
31289 --- Conduct Disorder, Unspecified
30011 --- Conversion disorder
30113 --- Cyclothymic disorder
29300 --- Delerium due to....GMC
78009 --- Delirium NOS
29710 --- Delusional disorder
29410 --- Dementia due to .....
29480 --- Dementia NOS
29011 --- Dementia/alzheim/erly/delerium
29012 --- Dementia/alzheim/erly/delusion
29013 --- Dementia/alzheim/erly/depressd
29010 --- Dementia/alzheim/erly/uncpl

29625 --- Mjr depr/singl/part remission
29636 --- Mjr depress recurr/full remiss
29635 --- Mjr depress recurr/part remiss
29634 --- Mjr depress recurr/sev/w psych
29633 --- Mjr depress recurr/sev/wo psyc
29630 --- Mjr depress recurrent/mild
29631 --- Mjr depress recurrent/mild
29632 --- Mjr depress recurrent/moderate
29626 --- Mjr depress/singl/full remiss
29624 --- Mjr depress/singl/sever/w psy
29623 --- Mjr depress/singl/sever/wo psy
31800 --- Moderate mental retardation
29383 --- Mood disorder due to.....
29690 --- Mood disorder NOS
30181 --- Narcissistic personality dsrdr
34700 --- Narcolepsy
99552 --- Neglect of child
V6121 --- Neglect/phys/sex abuse child
33392 --- Neuroleptic malignant syndrome
33370 --- Neuroleptic-induc acu dystonia
33399 --- Neuroleptic-induc acute akathi
33210 --- Neuroleptic-induc Parkinsonism
33382 --- Neuroleptic-induc tardive dysk
30510 --- Nicotine dependence
30747 --- Nightmare disorder
V7109 --- No Diagnosis on Axis I or II
V1581 --- Noncompliance w/treatment
30030 --- Obsessive-compulsive disorder
30140 --- Obsessive-compulsive persnalty
V6220 --- Occupational problem

29625 --- Mjr depr/singl/part remission
29636 --- Mjr depress recurr/full remiss
29635 --- Mjr depress recurr/part remiss
29634 --- Mjr depress recurr/sev/w psych
29633 --- Mjr depress recurr/sev/wo psyc
29630 --- Mjr depress recurrent/mild
29631 --- Mjr depress recurrent/mild
29632 --- Mjr depress recurrent/moderate
29626 --- Mjr depress/singl/full remiss
29624 --- Mjr depress/singl/sever/w psy
29623 --- Mjr depress/singl/sever/wo psy
31800 --- Moderate mental retardation
29383 --- Mood disorder due to.....
29690 --- Mood disorder NOS
30181 --- Narcissistic personality dsrdr
34700 --- Narcolepsy
99552 --- Neglect of child
V6121 --- Neglect/phys/sex abuse child
33392 --- Neuroleptic malignant syndrome
33370 --- Neuroleptic-induc acu dystonia
33399 --- Neuroleptic-induc acute akathi
33210 --- Neuroleptic-induc Parkinsonism
33382 --- Neuroleptic-induc tardive dysk
30510 --- Nicotine dependence
30747 --- Nightmare disorder
V7109 --- No Diagnosis on Axis I or II
V1581 --- Noncompliance w/treatment
30030 --- Obsessive-compulsive disorder
30140 --- Obsessive-compulsive persnalty
V6220 --- Occupational problem

30550 --- Opioid abuse
30400 --- Opioid dependence
31381 --- Oppositional defiant disorder
60889 --- Other male sexual dysfunction
30590 --- Other/unknown substance abuse
30490 --- Other/unknown substance depend
30789 --- Pain disdr w/psycho & GMC
30780 --- Pain disdr w/psycho factors
30021 --- Panic disorder w/agoraphobia
30001 --- Panic disorder w/o agoraphobia
30100 --- Paranoid personality disorder
V6120 --- Parent-Child relational pbx
V6110 --- Partner relational problem
31231 --- Pathological gambling
30220 --- Pedophilia
31010 --- Personality chg due to....GMC
30190 --- Personality disorder NOS
29980 --- Pervasive dev disorder NOS
31539 --- Phonological disorder
99581 --- Physical abuse of adult
99554 --- Physical abuse of child
V6283 --- Physical or Sexual Abuse of Ad
30752 --- Pica
30480 --- Polysubstance dependence
30981 --- Posttraumatic stress disorder
30275 --- Premature ejaculation
31820 --- Profound mental retardation
29890 --- Psychotic disorder NOS
29381 --- Psychotic due to....w/delusion
29382 --- Psychotic due to....w/hallucin

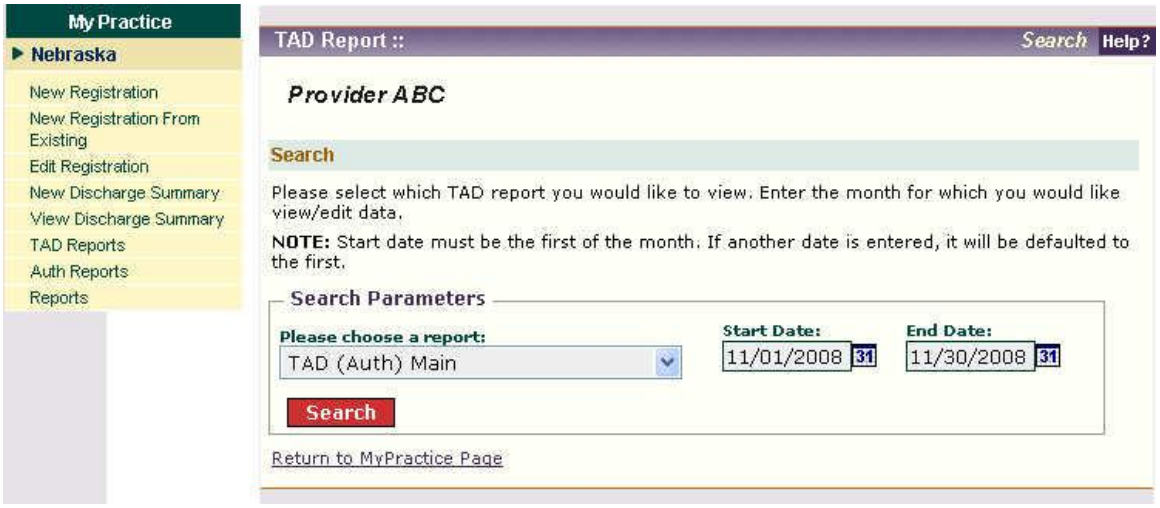
31233 --- Pyromania
31389 --- Reactive attachmnt infant/chld
31500 --- Reading disorder
V6190 --- Relational prob due mental/GMC
V6281 --- Relational problem NOS
30753 --- Rumination disorder
29570 --- Schizoaffective disorder
30120 --- Schizoid personality disorder
29520 --- Schizophrenia catatonic type
29510 --- Schizophrenia disorganized typ
29530 --- Schizophrenia paranoid type
29560 --- Schizophrenia residual type
29590 --- Schizophrenia undifferentiated
29540 --- Schizophreniform disorder
30122 --- Schizotypal personality disord
30410 --- Sedative/hypnotic/anxiolytic
30540 --- Sedative/hypnotic/anxiolytic
31323 --- Selective mutism
30921 --- Separation anxiety disorder
31810 --- Severe mental retardation
99583 --- Sexual abuse of adult
99553 --- Sexual abuse of child
30279 --- Sexual aversion disorder
30290 --- Sexual disorder NOS
30270 --- Sexual dysfunction NOS
30283 --- Sexual masochism
30284 --- Sexual sadism
29730 --- Shared psychotic disorder
V6180 --- Sibling relational problem
30746 --- Sleep disorder

Appendix (VI)

Turn Around Documents (TAD) Reporting

To access the application:

Go to www.Magellanprovider.com
Sign in with your secure Provider Name and password.
Click the **Nebraska** link on the left menu of the Welcome Page.
Choose 'TAD Reports' to enter encounter data.



Search page for TAD registered/authorized services:

1. Choose a report from the drop down box. TAD type choices are listed below:

   - O TAD (Auth) Main
   - O TAD (Auth) Intensive Outpatient
   - O TAD (Auth) Community Support SA
   - O TAD (Auth) Community Support MH
   - O TAD (Auth) Day/Res Rehab
   - O TAD (Regs) Outpatient
   - O TAD (Regs) Registered

Services are grouped under the seven TAD types as follows:

TAD (Auth) Main - This report displays Authorization Number, Member Name, SSN, Authorization Period, Days Authorized, Actual Days, Level of Care and Total Treatment Units. Consumers are categorized into the following Levels of Care:

- Assertive Community Treatment (ACT)
- Assertive Community Treatment (ACT) Alternative
- Secure Resident - MH
- Intermediate Res - SA
- Intermediate Res - MH
- Short-term Res - SA
- Therapeutic Com - SA

- Dual Dis Res/MH
- Dual Dis Res/SA
- Acute Psy Inpatient
- Half-way House - SA
- Day Treatment – MH
- Partial Care – SA

TAD (Auth) Intensive Outpatient - This report displays Authorization Number, Client Name, SSN, Authorization Period, Hours Authorized, Actual Hours, Level of Care and Treatment Units. Consumers are categorized into the following Levels of Care:

- Intensive O/P – MH
- Intensive O/P – SA

TAD (Auth) Community Support SA - This report displays Authorization Number, Client Name, SSN, Authorization Period, Months Authorized, Actual Months, Level of Care and Treatment Units. Consumers are categorized into the following Levels of Care:

- Community Support SA

TAD (Auth) Community Support MH - This report displays Authorization Number, Client Name, SSN, Authorization Period, Months Authorized, Actual Months, Level of Care, Treatment Units, MRO Yes and MRO No. Consumers are categorized into the following Levels of Care:

- Community Support MH

TAD (Auth) Day Res/Rehab - This report displays Authorization Number, Client Name, SSN, Authorization Period, Days Authorized, Actual Days, Level of Care, Total MRO Yes Units, Total MRO No Units and Treatment Units Consumers are categorized into the following Levels of Care

- Day Rehabilitation
- Psychiatric Residential Rehabilitation

TAD (Auth) Outpatient - This report displays Client Name, SSN, Actual Units, Level of Care and Treatment Units. Consumers are categorized into the following Levels of Care:

- Outpatient - MH
- Outpatient - SA
- Outpatient – Dual Dx

TAD (Auth) Registered - This report displays Client Name, SSN, Admit Date, Actual Units and Level of Care with Total Treatment Units for each consumer seen by the provider. The consumers are categorized into the following Levels of Care:

Assess/Eval Only – SA	Day Support
Assess/Eval Only – Justice	Detox
CPC	EPC
Ch Day Treatment	Emer Psych Obs 23:59
Ch Halfway House	Emergency Comm Supp
Ch Home Based MST	Family Navigator
Ch IOP –SA	Int Case Mngt – MH

Ch Med Management	Int Case Mgnt – SA
Ch O/P – MH	Medication Management
Ch O/P - SA	OpiodRplace - MethBup
Ch Ther Community	O/P Dual Dx
Ch Partial	O/P – MH
Ch Prof Part School	O/P – SA
Ch Prof Partners	Pre-Auth
Ch Yth Assess Only – MH	Psych Respite
Ch Yth Assess Only – SA	Psychological Testing
Ch Respite	Recovery Support
Crisis Assess/Eval – MH	Supported Employment
Crisis Stabilz/Tx	Supported Living
Crisis Assess LDAC – SA	

2. Select the appropriate TAD and and enter the Start Date and End Date for the TAD report. Date ranges must be from the first day of the selected month to the last day of the selected month. Dates crossing multiple months cannot be entered.

3. Click on 'Search' and the web will display the TAD information pertaining to the selected report.

4. Enter the encounter data associated with each consumer for the month selected in the fields on the right hand side of the TAD report. Encounter data should be entered monthly for each consumer receiving services.

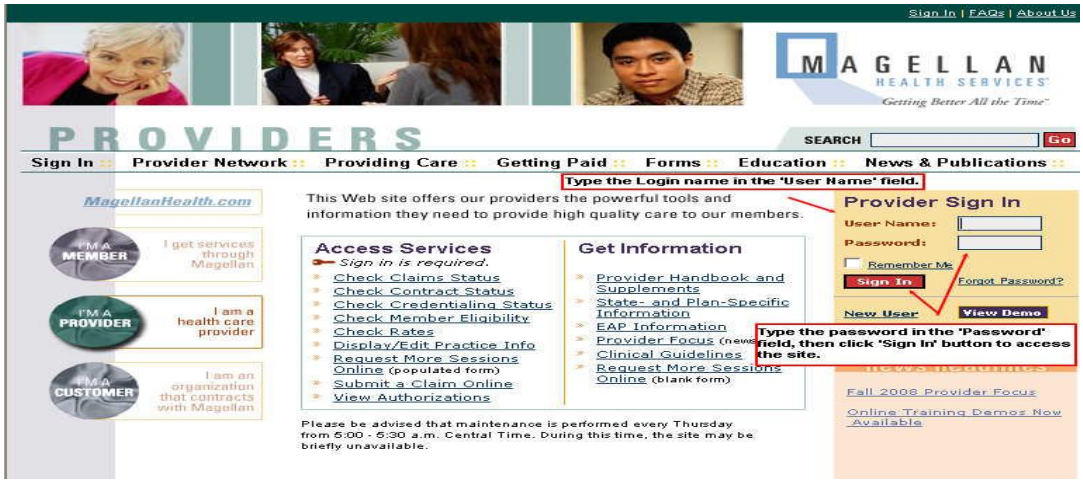
To continue using the Nebraska web site, select a link from the menu bar at the left.
To leave the Magellanprovider.com site, click on the 'Sign Out' link at the top of the page.

Appendix (VII)

Annual Re-Registration Process

All registered services are required to be updated annually in order to ensure that consumer information is up to date. This process also facilitates Federal NOMS reporting for registered services. Each month the "Annual Re-Registration Report" will be updated for each provider on the MagellanProvider.com web site. The report lists all the consumers whose registrations will lapse during that month. Providers need to review the report and re-register any consumers who are continuing in services. Those consumers who are no longer in services that appear on the report should be discharged. If Re-Registration is not completed by end of month following the Re-Registration Due Date noted in the report, the case/episode/encounter will no longer appear on the TAD.

1. To complete the Re-Registration process login to the magellanprovider.com web using the assigned username and password.



2. **Select Reports** from the links on the left hand side of the screen that appears:

3. **Select** the Annual Re-Registration Report from the choices in the drop down menu.

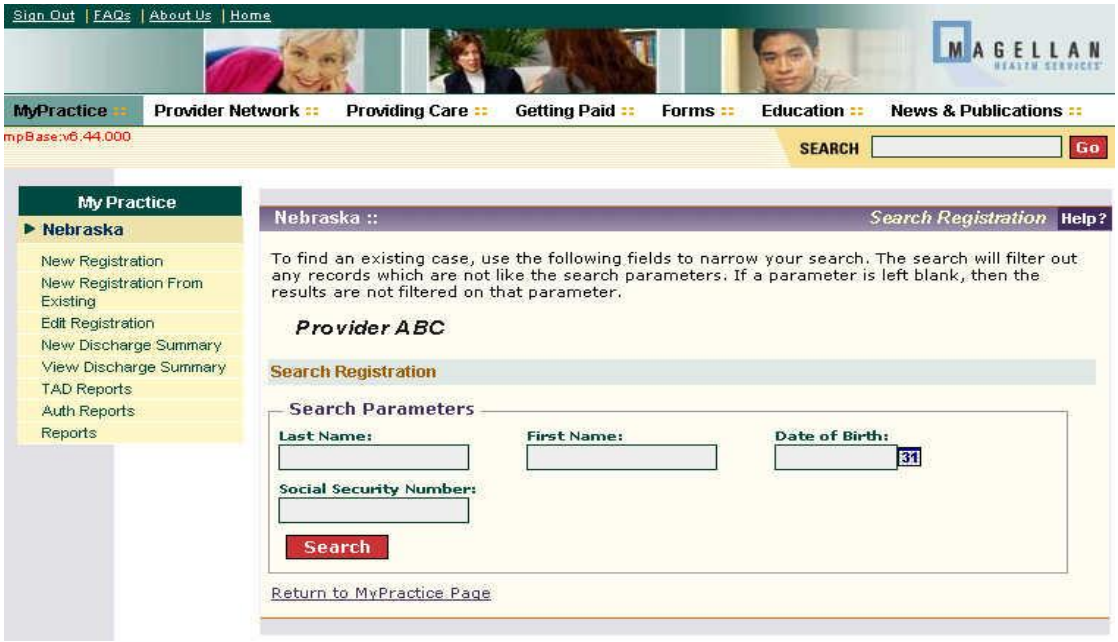
4. A report containing the information below will appear.

Svc Type	Prov ID	Provider	Pt Name	SSN	Case	Epi	Enc	Re-Reg Due Date	Auth Exp
Supp Emp	556821000	Acme	John Doe	123456789	xxxxxxxxxx	xxx	xxxx	01/2010	01/12/2010
Supp Emp	556821000	Acme	Sam Doe	234567891	xxxxxxxxxx	xxx	xxxx	01/2010	01/23/2010
Supp Emp	556821000	Acme	Bill Doe	345678912	xxxxxxxxxx	xxx	xxxx	01/2010	01/16/2010

5. **Review** the report to determine those consumers who will continue to receive the services listed.

6. **Select** "Edit Registration" from the links on the left hand side of the web screen.

7. **Enter** the consumer's SSN in the search screen that appears:



8. **Chose** the service to be re-registered from the list of services the consumer is receiving.

9. **Review** and update any necessary information on page (1) of the registration.

10. On page (2) of the registration, **change the admission** date to the day after the "Auth Exp" date that appears on the Re-Registration Report for that consumer.

11. **Review** and update any necessary information on page (3) and page (4) of the registration.

12. Be sure to click on the SAVE button at the bottom of registration Page (4). This will complete the online re-registration process. If your submission successful was successful you will see the message below.

Submission Complete

Your request has been successfully saved.

Return to MyPractice Page

Appendix (VIII)

Frequently Asked Questions (FAQ's)

1. **"I have a new client, what link do I select to enter the new consumer information?"** Select the 'New Registration' link to data enter new client information. From this link, you can complete all the required NBHS fields. See page (18) of the manual.

2. **"I want to enter another encounter for an existing consumer, what link do I select?"** Select the 'New from Existing Registration' link. From this link, you can use an existing record to pre-populate a new one. Find the existing consumer record using the search screen as described on page (18). Update/change existing the necessary consumer registration/demographic information and select a new level of care. Go to the last page of the registration and select **"Save"** to complete the process. **Note:** This link should not be used if you only want to update/change an existing registration as it will create another registration.

3. **"I need to update registration/demographic information for an existing consumer record, what link do I select?"** Select the 'Edit Registration' link to update/change existing client registration/demographic information. Find the existing consumer record using the search screen as described on page (18). Update/change the necessary consumer registration/demographic information. Go to the last page of the registration and select **"Save"** to complete the process. **Note:** This link will only update/change existing client information it will not create a new encounter for that consumer.

4. **"My login account has been locked."** Users are allowed three (3) attempts to login correctly to the MagellanProvider.com site. After three (3) incorrect attempts, the user's login account is locked. Contact the Magellan Nebraska Care Management Center 1-800-424-0333. Your login account will be reset and a new password will be issued.

5. **I discharged the wrong level of care and now I can't get into the record to correct it!"** Once a discharge date has been entered and saved, the record is locked. Go to www.MagellanofNebraska.com. Select "Quick Links" from the menu on the right of the screen. Choose "Forms and Processes". Download the "Behavioral Health Authorization Modification Request Form". Complete the form and fax it to the Magellan Nebraska Care Management Center 1-800-848-5685 to have corrections made to records that have been discharged.

6. **I have a "Pre-Authorization" that I don't need, but I can't delete it.** Go to www.MagellanofNebraska.com. Select "Quick Links" from the menu on the right of the screen. Choose "Forms and Processes". Download the "Behavioral Health Authorization Modification Request Form". Complete the form and fax it to the Magellan Nebraska Care Management Center 1-800-848-5685 to have the pre-authorization deleted.

7. **I entered a consumer Social Security Number incorrectly and the system won't let me change it.** SSN's are one of the few fields providers cannot update using the "Edit Registration" process. SSN's can only be corrected by Magellan Nebraska Care Management Center staff. Go to www.MagellanofNebraska.com. Select "Quick Links" from the menu on the right of the screen. Choose "Forms and Processes". Download the "Behavioral Health Authorization Modification Request Form". Complete the form

and fax it to the Magellan Nebraska Care Management Center 1-800-848-5685 to have the SSN corrected.

8. **I entered a consumer name incorrectly – what do I need to do to correct it?** Almost any field can be updated by providers. Social Security Numbers and Authorized Level of Care cannot be changed by the provider. Select the 'Edit Registration' link under the "My Practice" menu. Find the consumer record using the search screen as described on page (18). Update/change existing the necessary consumer registration/demographic information. Go to the last page of the registration and select **"Save"** to complete the update process.

9. **I created a new record using the "New from Existing Registration" process for Outpatient-MH services. Now my Community Support-MH authorization is missing from the "Turn Around Document". What do I do?** When this occurs it is generally because "Edit Registration" rather than "New from Existing Registration" was used. And when the "Level of Care" field was completed for the Outpatient-MH service it "overwrote" the Community Support-MH authorization. This can only be corrected by Magellan Nebraska Care Management Center staff. Go to www.MagellanofNebraska.com. Select "Quick Links" from the menu on the right of the screen. Choose "Forms and Processes". Download the "Behavioral Health Authorization Modification Request Form". Complete the form and fax it to the Magellan Nebraska Care Management Center 1-800-848-5685 to have the Community Support-MH authorization restored.

10. **I completed a Pre-Authorization and spoke with a Magellan Care Manager to complete a Community Support-MH authorization, but it's not showing up on my Medicaid Authorization report. What do I do?** This can occur for a number of reasons ranging from data entry errors to eligibility issues. If the authorization is not on your authorization report within twenty-four hours of your call to the Magellan Care Manager complete the "Behavioral Health Authorization Modification Request Form". The form can be downloaded from the www.MagellanofNebraska.com website. Select "Quick Links" from the menu on the right of the screen. Choose "Forms and Processes". Download the "Behavioral Health Authorization Modification Request Form". Complete the form and fax it to the Magellan Nebraska Care Management Center 1-800-848-5685 to have the authorization corrected.